# Better Together

**A Report on the African Regional Conference on Men's Participation in Reproductive Health, Harare, Zimbabwe, December 1-6, 1996**

# Conference Organizers and Participants

The conference was hosted by Zimbabwe's leading family planning organization and was co-sponsored by two USAID-funded cooperating agencies and the IPPF/Africa Region.

***Zimbabwe National Family Planning Council (ZNFPC).*** ZNFPC is the driving force behind Africa's pioneering and successful Male Motivation project (1988-89) and the follow-up Male Motivation and Method Expansion project (1992-94). It has been the leading family planning organization in Zimbabwe since 1967.

***The Johns Hopkins University/Population Communication Services (JHU/PCS).*** JHU/PCS has worked for more than a decade to produce IEC campaigns and materials to reach both men and women, individually and as couples, in Africa. PCS, with USAID support, has provided technical assistance and funds to more than 25 programs addressing men's participation, working with many African governments and NGOs to help design and manage male-motivation campaigns, including Zimbabwe's.

JHU/PCS projects have used mass-media channels such as radio, television, and newspapers to reach men through the programs and events they enjoy, including sports events, theater, films, and music.

These programs have significantly increased men's willingness and ability to talk with and listen to spouses, partners, peers, and health providers, and have mobilized men to discuss their concerns in community meetings.

The Male Motivation Task Force, a special team within PCS, coordinated the conference planning and follow-up.

***International Planned Parenthood Federation (IPPF)Africa Regional Office (Lome and Nairobi).*** IPPF has pioneered the promotion of men's participation in such areas as service delivery, counseling, condom marketing, and workplace distribution for decades, through the local efforts of its many African affiliates and by means of international conferences and research studies.

IPPF has sponsored two conferences on men's participation (Gambia 1991 and London 1994), and recently began baseline surveys in Kenya and South Africa for its Year 2000 Fund male motivation project, entitled "Men, the Forgotten 50 Percent."

***Support for Analysis and Research in Africa/Academy for Educational Development (SARA/AED).*** SARA is a USAID-funded program administered by the Academy for Educational Development (AED) to promote using research in Africa to improve reproductive health and other development sectors, and to make that research available to policy makers. For several years SARA has played an important role in research, analysis, dissemination, policy and program development, and advocacy, to promote reproductive health for both men and women, and in particular, to fighting HIV/AIDS.

SARA's recent analysis of men's participation in Africa, its review of the literature on African men's family planning attitudes and behaviors, and the draft manual of *An Introduction to Advocacy* were distributed at the conference and provided important background information.

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# Preface and Acknowledgments

Most reproductive health and family planning efforts have historically focused on women. In recent years, however, the recognition has grown that men significantly influence reproductive decisions and play an important role in reproductive health programs. This has led to new communication projects that promote men's participation in family planning and reproductive health.

The *African Regional Conference on Men's Participation in Reproductive Health* was convened in order to review the *lessons learned* from African organizations over a decade of communicating with men about reproductive health. The lessons apply to designing and implementing programs, advocating and winning support for programs, and evaluating program results. This report provides an overview of the rationale, research input, results, and outcomes of the conference. It also provides concrete recommendations for action to further men's participation in reproductive health in Africa.

The conference was co-sponsored by Johns Hopkins University/Population Communication Services (JHU/PCS), the Academy for Educational Development/Support for Analysis and Research in Africa project (AED/SARA) and the International Planned Parenthood Federation/Africa Region (IPPF/AR). Dr Lalla Toure and Ritu Sharma of AED/SARA and Rebecca Kohler of IPPF/AR were instrumental in the design and implementation of the conference and provided input on the conference report.

Funding for the conference was provided by the United States Agency for International Development (USAID) Office of Population and Africa Bureau, and by IPPF/AR. Dr. Phyllis Gestrin of the Africa Bureau and Dr. Chloe O'Gara, former Technical Advisor at the USAID Office of Population, provided invaluable support. The USAID Missions of the Regional Economic Development Services Office (REDSO) for Eastern and Southern Africa and REDSO West and Central Africa, Tanzania and Zimbabwe, particularly the latter through Peter Benedict, Mission Director, and Roxana Rogers, Family Planning Coordinator, were strong supporters throughout.

In Zimbabwe, Dr. Alex Zinanga, Executive Director of the Zimbabwe National Family Planning Council (ZNFPC), had the able assistance of the Deputy Director Dr. Beauty Ncube, Godfrey Tinarwo and Fatima Bopoto of the ZNFPC IEC Unit and many others in orchestrating ZNFPC's role as conference host. The Honorable Mrs. Joyce Mujuru, Minister of Information, Posts and Telecommunications, and the Honorable Dr. Timothy Stamps, Minister of Health, showed their official and personal support in opening, closing, and actively participating in the conference. Ben Zulu was media coordinator. Wanda Kawadza was conference logistics coordinator.

Godfrey Tinarwo of ZNFPC, Mary Kotei, Director of the Health Education Unit of the Ministry of Health in Ghana, Dan Odallo, Resident Advisor for JHU/PCS in Kenya, Dr. David Wilkinson of AVSC Africa Region,
Dr. A. B. Soulaiman, Executive Director of Planned Parentfood Federation of Nigeria, and Nii Adote Addo, Director of Programs Planned Parenthood Association of Ghana, each presented a case study to the conference.

At PCS, the Men's Participation Task Force, including Patrick Coleman, David Awasum, Ian Tweedie,
Peter Roberts, and Jane Brown organized the conference in collaboration with AED/SARA and IPPF/AR. Lorna Shaffritz and Paula Hollerbach of AED prepared a literature review. Susan Krenn, the PCS Africa Division Chief, Karungari (Karusa) Kiragu, Carlyn Saltman, Mwelu Ndeti, Robert Riccio, Kristina Samson, Catherine Sheets and Jane Koehler made contributions in support of the conference. Special thanks to Susan Leibtag, Margaret D'Adamo, Nicole Pelsinsky, and Michael Lawes of the JHU/CCP Media/Materials Clearinghouse for their support in preparing materials for the conference.

Consultant Nick Danforth was the conference rapporteur and co-authored the conference report with Peter Roberts.

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April 1997

# The African Regional Conference on Men's Participation in Reproductive Health

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## *Dedication*

In Harare, Zimbabwe, at 5:00 a.m., on Monday April 14, 1997, Florence Chikara passed away. Florence was a thinker, doer, friend, and a leader with a clear focus on achieving great social goals.

She had a clear vision for what needed to be done and spent all of her energy in the pursuit of that goal—to work with the Zimbabwe National Family Planing Council to promote informed choice in family planning and reproductive health for all of Zimbabwe's citizens. The *Earth Times* had ranked Florence one of the 100 most influential people in the world in the field of development.

This conference was held in Zimbabwe largely because it was the site of one of Africa's most successful Male Motivation projects. Florence Chikara was instrumental in spearheading that project for the Zimbabwe National Family Planning Council and was a key to its success. It was Florence's indomitable spirit and dedication to her work which inspired many of those gathered for this conference.

This report is dedicated to her.

# Harare Declaration on Men's Participation in Reproductive Health in Africa

## Preamble

We, the 66 participants at the Africa Regional Conference on Men's Participation in Reproductive Health representing 15 nations of sub-Saharan Africa, having met to discuss and discover new approaches and solutions to communication, service, and policy challenges to increasing men's participation in reproductive health, hereby declare that we fully support efforts to build upon the important work of many African governments and NGOs as well as the UN agencies to promote men's responsible, equitable role in reproductive and sexual health and the health of women and children.

## Challenges to Men's Participation

We face similar serious challenges in increasing men's participation at the:

- *Individual level*, where many African men lack information about reproductive health, and couples are often unable to discuss and reach shared decisions about sexuality and contraception;
- *Community level*, where religious and traditional values favor men having large families, and where changed social structures result in increased STD/HIV transmission, unwanted pregnancies, and other reproductive health problems;
- *Institutional level*, where men's access to reproductive health information and services is hindered by existing structures that do not meet their needs;
- *Policy level*, where laws and regulations limit men's access to reproductive health information and services.

## Areas for Action

We believe that all such challenges must be addressed to build effective participation of men as caring and understanding partners.

## Communication to Increase Men's Participation

Strategic communication programs should effectively address the information needs of diverse groups of men and change social norms to provide an enabling environment for partner communication and shared decision-making. Young men need particular attention. Programs should build on traditional African values such as men's responsibility for the welfare of their families, the importance of spacing pregnancies, and respect for traditional authorities.

## Communication in the Context of Service Delivery

A broad range of integrated, quality reproductive health services including information and counseling tailored to men's needs should be provided by public, private, and commercial organizations. Special training is needed to counsel men.

## Policy Advocacy

Public and private institutions and individuals should create, through effective advocacy, a legal, regulatory, and political environment at all levels that encourages and sustains men's participation in reproductive health.

In conclusion, we maintain that reproductive health is neither "men's" nor "women's," but requires participation of both. Communication must ensure that both partners are reached with information and enabled to access services that meet their varied needs.

*We Africans, we face a minefield, a terrible minefield: ever-increasing sexually transmitted diseases and AIDS. Women hold up half the sky, but now things are skewed. What about the other half of the sky? We need balance. But we must be cautious; we have entrenched traditions. What can we do, sons and daughters of Africa?*

*Together, we have a golden opportunity change. Together, African men and women, can be partners.*

*Mrs. Joyce C. Kadandara*
*World Health Organization Representative, Zimbabwe*

*We need to be helped to space our children, not look at them dying.... We women want family planning, but how do we deal with our husbands? You need to talk to them, so they can accept.*

*Burkina Faso woman whose child had just died,*
*quoted by Dr. Lalla Toure AED/SARA Project*

*Maybe men and women need to practice more "aural sex." That is, talk to each other more, communicate about sexuality and family planning.*

*The Hon. Dr. Timothy Stamps*
*Minister of Health Zimbabwe*

# The African Regional Conference on Men's Participation in Reproductive Health

*Reproductive health is neither men's nor women's but requires the participation of both.*

## Executive Summary

### Men's Participation: A Reproductive Health Programmatic Necessity

While men's participation in reproduction is, by definition, a physical necessity, men's participation in reproductive health has been, mostly negligible and neglected. There is a growing understanding, however, that for reproductive health programs to work as a whole, men's participation is also a *programmatic* necessity. Changing African men's reproductive health behavior is essential not only for their health but also for that of women. The issue is no longer *whether* to institute programs that include men, but *how to* do so.

With this latter premise in mind sixty-six leaders, high-level planners and managers of health and communication programs from seventeen Anglophone African countries (and coincidentally equally divided by gender) met in Harare, Zimbabwe, in December, 1996 for the first *African Regional Conference on Men's Participation in Reproductive Health*. The purpose of the conference was to discuss solutions to the many challenges facing African men's participation in reproductive health, particularly those challenges related to communication, and to apply those lessons in program planning.

Reflecting the mandate of its co-sponsors, the conference examined three major areas of communication in reproductive health:

- Information, Education and Communication (IEC);
- Communication in the context of service delivery; and
- Policy advocacy.

The conference was:

- ***Research-based***, in taking as its starting point the lessons learned from an extensive review of the literature on men's participation;
- ***Experience-based***, in building upon the field experiences of individuals and organizations who had designed, implemented and evaluated different types of men's programs in many countries around Africa;
- ***Participant-focused***, in soliciting the identification by each participant of the key challenges he or she faced, synthesizing those challenges and integrating them into the thematic framework of the conference; and,
- ***Action-oriented***, in having each participant make a "pledge" outlining a specific and realistic plan of action to be initiated on his or her return home; in publishing the Harare Declaration which called for the integration of men's participation concerns into all continuing and future reproductive health programs; and in announcing *The Challenge Cup: A Sports Initiative*, which focuses on innovative sports programs as an entry point into men's reproductive health issues.

Participants emphasized that it was important to see men's programs not as separate from and therefore often in competition with women's programs, but as part of an integrated approach to reproductive health which created a synergy of complementary and mutually supportive men's and women's programs.

The Harare conference laid out a blueprint for developing new strategies and policies to meet the many challenges to men's participation through a number of tangible outcomes.

The conference is one in a series already held, or planned for in Africa in 1997:

• Earlier in 1996, MACRO International, the World Health Organization (WHO) and AED/SARA chaired a conference in Senegal on *the DHS findings on men and reproductive health*; this Harare conference focused on *communication*;

• AVSC will host a conference in Mombasa, Kenya on *service delivery* in May, 1997;

• CEDPA will sponsor a conference on *gender issues* planned for late 1997, host country and exact date are yet to be finalized; and,

• JHU/PCS, AED/SARA, and other co-sponsors plan a second conference on *communication* for *Francophone* Africa planned for late July 1997 in Ouagadougou, Burkina Faso.

## Men as Family Planning Decision-Makers

Men's roles are important because most leaders and policy makers are men and as such play the major role in designing, planning, funding, and managing reproductive health policies and programs. In many African families, men decide on the number of children and typically report wanting more children than their wives. Usually men, not women, determine whether modern family planning is used. Because men in Africa are such powerful decision-makers in the family and in the community, they are the gatekeepers to contraceptive use, not only in families, but also in clinics, communities, workplaces, organizations, and local and national governments.

There is an important precedent for men in Africa to be family planning decision-makers: traditionally, they played a key role in helping their wives space births by practicing withdrawal and periodic abstinence. The Population Reference Bureau, using data from the Demographic Health Surveys for 11 African countries, found that both husbands and wives report overwhelmingly that they approve the principle of family planning.

The same study reports that a third to a half of African husbands want no more children, are more knowledgeable than their wives about contraception, and are more likely than their wives to use modern contraception. Recent vasectomy programs in Kenya show that some men will use even this permanent method if it is available and accessible.

Perhaps more than any other factor, the explosion of HIV/AIDS and other sexually transmitted diseases in Africa has dramatically increased men's concern about reproductive health. Before the AIDS pandemic, women were far likelier than men to die from unsafe sex because of the risks of pregnancy and childbirth, as well as STDs; now, unprotected sex can be lethal for men as well.

In short, despite their traditional images as opponents of family planning, many African men are, in fact, advocates—or potential advocates—for reproductive health behaviors and family planning services.

Men can advocate family planning and reproductive health.

## Working Groups

Conference participants identified five key sub-themes which must be given consideration in the design, implementation and management of effective communication programs for men. Each of these sub-themes was the focus for discussion in working groups which met on three afternoons. They looked at men as **different audiences**; at **young men** and their particular concerns; at **integration** of IEC for men into reproductive health; at **cultural challenges** to men's participation; and at **sustainability** of men's programs.

Among the groups, there was consensus on a number of cross-cutting issues. They agreed that recognizing men's diversity in all its dimensions—in age, education levels, socioeconomic status, family situation, work environment, etc.—and deciding how to reach and serve the needs of these different categories of men are communicators' biggest tasks. Programs must use diverse channels of communication to reach men at home, at work, at religious and social events, in schools and community centers and wherever they receive educational or commercial messages.

There need to be more and better IEC materials directed towards men; more messages which support the idea of increased communication between partners; new and updated training curricula to address the specific issues of counseling men; more men recruited and trained as service providers— whether as CBDs or in clinics or in the workplace; better support from private practitioners, PVOs, and NGOs to offer services to men (every employer can provide reproductive health education and referral to services as part of their employee benefits); and, better advocacy among leaders to support laws, policies, and funding that ensure that all young men and women receive basic education about reproductive and sexual health and have better access to services.

## Participant Pledges

On the final day of the conference, participants made pledges to work toward increasing men's participation using the communication and advocacy strategies discussed in Harare. These pledges provided an innovative, relevant and action-oriented bookend to the participants' challenges which had helped frame the discussion at the outset of the conference. Participants submitted objectives, target audiences, impact indicators, costs, and timelines. They worked individually and in teams.

The most common feature of the programs envisioned in these pledges is information, education, and communication, using both mass media and interpersonal communication campaigns designed to reach men and couples. Equally important are plans for advocacy-—persuading high-level policy makers and program managers to increase communications and services for men and for couples. About half the pledges are related to ongoing programs, and half to new programs.

### Challenge CUP: Men's Reproductive Health and Sports Initiative

*The Men's Sports Initiative Challenge CUP* was announced by Johns Hopkins Center for Communication Programs. The Challenge *CUP* (for ***C****aring* ***U****nderstanding* ***P****artners*) is a program of matching grants to African organizations involved in promoting reproductive health to men through sports. The goals are to build on sports' mass appeal and existing infrastructure in Africa to encourage and reinforce men's active participation in family planning and the prevention of HIV/AIDS/STDs; to expand interpersonal communication among team members, their families, and their friends about acceptance of family planning and safe sex practices; and to increase the use of family planning methods. Matching grants of up to$50,000 for each of two countries will be awarded to government organizations, private/ commercial groups, or NGOs, such as sports federations, that present proposals which best make use of local resources to foster the goals of the *Challenge CUP* initiative.

## The Harare Declaration

Building on the concept that advocacy is fundamental to men's participation activities at every level, participants ended the conference, not only with individual and team pledges, but also with a public declaration committing themselves to "efforts to build upon the important work of many African governments and NGOs, as well as donor agencies, to promote men's responsible and equitable role in reproductive and sexual health." (See page vii for the full text of the declaration.)

### Definition of Terms

*Male motivation, men's involvement* and *men's participation* are terms that have been commonly used as the generic descriptor for programs addressing men's issues in reproductive health. At the Harare Conference, the co-sponsors agreed to *Men's participation*, because we believe the term best promotes the ideal of voluntary, equitable, cooperation and collaboration between men and women.

At this conference, we examined the participation of men in family planning and reproductive health in the following areas:

- *the sexual and reproductive attitudes and behaviors of men*, such as the use of condoms and vasectomy; the practice of safer sex; and, seeking diagnosis and treatment of STDs and other reproductive and sexual problems;
- *the encouragement and support that men give* to their wives, partners, friends, and peers by understanding and helping them to achieve reproductive health;
- *the influence and leadership men provide* as policy makers and managers in advocating, developing, and sustaining reproductive health programs.

Because of the wide range of health concerns reflected among participants, some defined reproductive health more broadly to include maternal and child health. At the beginning of the conference, for example, Zimbabwe's Minister of Information defined reproductive health as "integrated" and included in it safe pregnancy and childbirth, the health and survival of the mother and child, and breastfeeding (as well as preventing STDs and unplanned pregnancy). For efficiency, however, the conference generally used the narrower meaning and did not cover men's important roles in maternal and child health.

## Key Recommendations

The key recommendations are a synthesis of what emerged from the various working groups and activities at the conference.

### *Research*

- Research should be expanded into understanding men's sexual and reproductive attitudes and behavior.
- Programs for men should build on traditional values that highlight men's responsibility for the well-being of their families.

### *Program Management*

- Programs addressing men should supplement rather than supplant programs for women; they should not be an alternative to or a threat to existing reproductive health programs.
- Communications organizations should develop strategic education and communication programs that address the diverse needs of different groups of men;
- Providers should meet the education and service needs of young men in particular;
- Health-care providers should nurture partner communication, cooperation, and shared decision-making in reproductive health;
- IEC and training materials are needed that address men's participation; and
- HIV/STD-prevention should be integrated into all health programs for both men and women.

### *Advocacy*

- Health-care providers should provide a broad range of integrated, quality health services tailored to men's needs, in the public, private, and commercial sectors;
- Individuals and public and private institutions should advocate and reinforce a total environment that encourages and sustains men's participation in reproductive health.

## ABOUT THE HARARE CONFERENCE

## Conference Themes

The Harare conference was the first to focus its attention on Men's Participation in Reproductive Health from the perspective of *Communication*. It focused on three communication-related themes: issues involved in *reaching* men with reproductive health messages through Information, Education and Communication (IEC); in *linking* those messages to services that meet men's (and young men's) needs; and in *advocating* policies that encourage men to participate.

**Theme 1. Information Education and Communication for Men and their partners**.
Before men will make greater use of existing or new services, they must perceive a *need* for those services and relate their own circumstance to that need. This is the role of IEC. Using carefully designed and pretested campaigns based on thorough research and intended for specific audiences—(for example, not just *men*, but particular groups of men such as young men, or married men who want no more children)—IEC can promote behavior change. Successful communication campaigns make use of multiple channels, encompassing mass media vehicles like newsletters and print, radio, TV, community-based media like folk theater, dance, motivational talks, and individually focused methods like counseling.
The synergy of multiple channels working in concert and all carrying the same key messages creates a behavioral change impact greater than the sum of the individual approaches.

The conference presentations on day one reviewed lessons that have been learned about *communicating with men* in many pilot men's programs in Africa. Communicators must understand not only the *obstacles* to men's participation--physical, mental, financial, and political-- but also the important factors predisposing men to be *advocates* for family planning and why that potential remains largely untapped. This conference set about to do exactly that.

**Theme 2. Communication in the context of service delivery.**
Communicators and service providers together must reach out to men and their partners. Regardless of the particular service delivery mechanism chosen to reach men, each will have its own specific *communication* needs: private, confidential, and individual counseling of men and their partners about sexual and reproductive health is a necessity; training of service providers in the intricacies of counseling men requires the development of new curricula and new methodologies; counseling and service provision needs to be supported by effective, accurate, inexpensive and readily available IEC materials such as leaflets, posters, flipcharts, and client-directed videos. IEC interventions need to be designed in conjunction with service delivery so that the expectations of clients are met with a commensurate increase.

**Theme 3. Communication and Advocacy**.
Policy advocacy is an essential task of all reproductive health care leaders, managers, and providers. Everyone working in the reproductive health field should understand the importance of advocacy and have basic advocacy skills. Policy advocacy, in the context of this conference, means working to improve the policies, positions, plans, and programs of all levels of governments, institutions, and organizations so that they can support and facilitate more active participation of men in reproductive health.

## Conference Structure

The conference took place over five days.
Day one was earmarked for discussion of issues involving *IEC*; day two focussed on communications issues that affect *service delivery*; day three saw delegates travel out to *observe* three separate men's programs which are an ongoing part of the Zimbabwe National Family Planning Council's (ZNFPC) Male Motivation program that has been running since 1992; day four reviewed various definitions of *advocacy* and its essential elements and objectives; day five comprised a distillation and synthesis of the issues and lessons learned, the presentation of "pledges" by each participant, the adoption of the Harare Declaration, the announcement of *The Men's Sports Initiative Challenge CUP*, and a review of next steps for men's participation in reproductive health in Africa.

The facilitators for each day's sessions came from the organization whose central mandate best matched each theme: JHU/PCS staff facilitated the *Communication* sessions; IPPF representatives facilitated *Communication*

*and Service Delivery*; and AED/SARA staff facilitated the discussions on *Advocacy*. Each day had a similar pattern: the morning session was given over to presentation of research and illustrative case studies, followed by plenary group discussions and the afternoon session involved small-group work. On each afternoon, five break-out groups examined that day's principal theme from the perspective of the major consensus issues:

- Men as different audiences
- Young men and their particular concerns
- Integration of IEC for men into reproductive health services
- Cultural challenges to men's participation
- Sustaining men's programs.

## A Cautionary Tale: Too Much Male Motivation?

The evaluation results of the Zimbabwe Male Motivation and Method Expansion Project (MM2) showed that though it was successful in most of its objectives, there was one unexpected and dismaying result. After the campaign men were more likely to believe that they *alone*, not jointly with their spouses, should be responsible for making reproductive health decisions. This finding suggests that though stereotypical male-oriented events like soccer matches, and testimonials from role models like national soccer team members, were very effective in reaching men., the campaign's reliance on these traditional masculine images may have reinforced stereotypes about men's decision-making authority and blurred the campaign's message on the value of joint decision-making. Though many of the messages did use the sports motif to emphasize *teamwork—To win the family planning game by reaching the goal of a small family with the help of their teammates (spouses/partners) and coaches (service providers)*—others may have reinforced men's willingness to take control alone: *Play the Game Right*, *Once You're in Control, It's Easy to Be a Winner*, and *It's Your Choice*.

The use, as part of one's communication strategy, of stereotypical images as a medium to carry messages is a delicate balancing act, requiring even greater diligence in the selection of the words and phrases which carry the key messages, particularly when directed towards men, who will quickly grasp any perceived opportunity to take control!

The working group on *Cultural Challenges* meets during a break-out session.

## RESEARCH-BASED FOUNDATION

The research presented on the first day and the compilation of experiences from the field shaped the major themes, the working group sub-themes and even the structure of the conference. There were three primary sources of information: a thorough *review of the literature* addressing men's participation in all its varied forms, with an emphasis on the African context; a review of *case studies* from around the world, involving men as a primary audience in projects such as the Zimbabwe *Male Motivation* campaign, or as secondary audiences integrated into a broader campaign such as the Ghana *Together We Care* campaign; and, a compilation and analysis of what participants perceived as the *principal challenges* they faced in their own countries, organizations, communities, and families.

The questionnaires which participants completed well ahead of the conference focused on communication barriers (such as sociocultural stereotypes that prevent men from getting involved in family health matters); challenges to serving men (such as that so few services are designed for them); and policy barriers (such as a lack of training for service providers in counselling men). Questionnaires were tabulated to determine the problems cited most frequently.

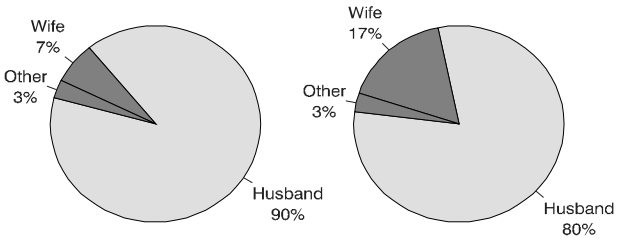
Interestingly, a large proportion of the obstacles participants cited about reaching men are also barriers to reaching women: pronatalist norms, reproductive health as the woman's domain, poor management of services, and fear of political backlash against family planning messages and media. Because reproductive health is traditionally seen to be a woman's need more than a man's, such challenges may appear greater to educators and communicators addressing men's reproductive roles for the first time. In that sense, the movements to involve men in reproductive health, by emphasizing the paucity of services available to men, may also help draw attention to the inadequacies of reproductive health services available to women.

What follows is a distillation of the key findings from all these sources, grouped into headings by issue rather than by origin. These findings were presented to the conference on the first morning.

**1. Men Are Powerful Decision-Makers, Advocates, or Opponents of Contraception.**
Men in Africa influence decisions within the couple, the home, and the community in many ways. Their power, a predominant factor in couples' reproductive and sexual decision-making, is a direct and indirect cause of high fertility as well as maternal morbidity and mortality--particularly due to HIV/AIDS. Because of that power, men can be key advocates of, or opponents to, contraceptive use, with both personal and demographic consequences.

Usually in Africa the decision-makers who shape social norms and public discourse that affect men's participation are male leaders.

Men Have Greater Influence Over Family Decisions




**Husband's Response** **Wives' Response**

Source: Uche C. Isuigo-Abanihe, "Reproductive Motivation and Family-Size Preferences Among Nigerian Men", *Studies in Family Planning*, Vol 25, No. 3, 1994.

The Hon. J.T.R. Mujuru, Zimbabwe Minister of Information, Posts, and Telecommunications and ZNFPC patron.

The Hon. Dr. Timothy Stamps, Minister of Health, Zimbabwe, speaking at the conference.

Men's roles are important because men play the major role in designing, planning, funding, and managing reproductive health programs.

In the words of the Zimbabwe Minister of Information, as she opened the conference,

***"In Africa, men have the final say in reproductive health issues, [so] in our reproductive health we ignore men only at our own peril, and that of society as a whole."***

Men also play an important health role by encouraging both their partners and peers to use contraception, to practice safer sex, and to seek reproductive health care.

In the words of the Zimbabwe Minister of Health as he closed the conference,

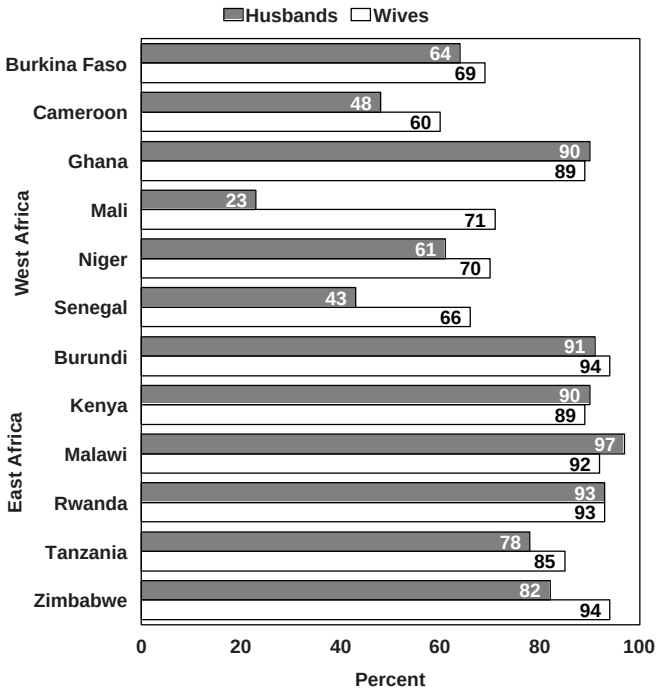
***"Maybe men and women need to practice more 'aural sex.' That is, they need to talk to each other more—to communi-cate better about sexuality and fertility."***

In many African families, men decide on the number of children and typically report wanting more children than their wives. Usually men, not women, determine whether modern family planning is used. And because men in Africa are such powerful decision-makers in the family and in the community, they are the gatekeepers to contraceptive use, not only in families, but also in clinics, communities, workplaces, organizations, and local and national governments.

**2. Many Men in Africa Have a Negative View of "Family Planning" Concepts and of Contraceptives.**

Despite the many ways men can and do benefit from family planning and (using condoms) disease prevention, and despite the

**Approval of Family Planning by Husbands and Wives**




*Source: DHS Comparative Studies, No.18, Macro International.*

overwhelming support of men throughout Africa for the general *concept* of "family planning," many men in Africa still have a negative interpretation of the *term* "family planning" because most associate it with limiting the family, rather than spacing the children. Many oppose specific types of contraception for themselves (condoms and vasectomy) and their partners.

**3. Men in Africa Are Nevertheless Predisposed to Be Potential Advocates of Family Planning.**
There are important precedents for men to be family planning decision-makers. Traditionally, men in Africa have played a key role in helping their wives space births by practicing withdrawal and periodic abstinence. The Population Bureau, using data from the Demographic Health Surveys for 11 African countries, found that both husbands and wives report overwhelmingly that they approve the principle of family planning.

The same study reports that a third to a half of African husbands want no more children, are more knowledgeable than their wives about contraception, and are more likely than their wives to use modern contraception. Recent vasectomy programs in Kenya show that some men will use even this permanent method if it is available and accessible.

In short, despite their traditional image as opponents of family planning, many men in Africa are potential advocates for reproductive health behaviors and family planning services.

**4. Men Have Limited Access to Reproductive Health Services.**
"Men's participation" was defined to include all sexual and reproductive behaviors of men, such as the use of condoms and vasectomy or the practice of safe sex, seeking clinical care for diagnosis and treatment of sexually transmitted diseases (STDs), and communicating with one's partner about these issues.

Unfortunately, fewer Africa-region reproductive health activities have been addressed to men than to women. There are many reasons for this:

- The urgent need for women to have privacy and autonomy in reproductive decision-making;
- The predominance and availability of female-controlled methods of preventing or terminating pregnancy, allowing men to perceive birth control or birth spacing to be the woman's exclusive responsibility;
- The traditional linking of family planning with maternal/child health care;
- The self-fulfilling prophecy that "men don't care about family planning, so we won't even try to teach them;"
- The predominance of female service delivery staff, some of whom are uncomfortable talking to men about sexuality and reproductive health;
- Hours of most clinics are not compatible with men's work schedules; and
- The lack of staff trained and able to discuss sexual health with men who are more likely than women to be concerned with and embarassed about discussing the relationship between sexual behavior and contraception.

The Zimbabwe Minister of Information described how, when family planning services were first introduced in her country, they were targeted at the female population. As a result, this created mistrust and misconceptions among men, many of whom were unwilling then to attend clinics or seek services.

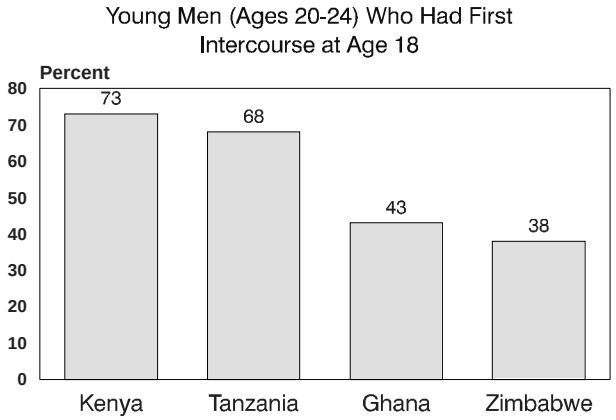
**5. Men do have distinct needs for counseling and services.**
A recent JHU/PCS study in Kenya found that Kenyan men are more interactive, asking more questions during counselling. Providers address a wider range of issues with men. When couples are counselled, men talk more than women. Counsellor training needs to be designed with these gender differences in mind.

In designing programs for men, managers need to examine the ways in which services for men are structured to increase men's use and satisfaction. Each of these options has implications for IEC as well as for service delivery itself:

- Male-only clinics
- Male service providers
- Wider range of services (general health services in addition to reproductive health care, sexuality counselling, infertility)
- Gender-neutral environments
- Special hours/special rooms
- Services for young men

- IEC materials for men/young men

Other questions arise about the efficacy of CBD agents in meeting men's needs: How can CBD agents provide better individual or couple counselling during home visits? Are male CBD agents likely to reach men? Will men and women CBDs working together be more effective in increasing couple communication and cooperation? How essential is the support of community leaders?




Source: DHS special tabulation by Macro International.

**6. Communication and services may be most successful when they go where men gather.**
It may be possible to reach more men in settings where they typically gather, either at work or at play, because men do not traditionally use reproductive health services. Men may be reached in industries, plantations and commercial farms; at office sites in the civil service; on military bases; in a sports team coaching environment; and, by working with professional groups and associations. The commitment of Senior management at these gathering places is essential for any of these options to be effective; workplace programs also require backup referral services (on or off the worksite) with private, confidential services.

Fellow workers/peers can provide motivation, education, creation of support networks, nonprescription commodity distribution, and referral to clinics.

**7. Government regulations and policies often restrict access and services.**
A wide range of regulations and policies restricts men's as well as women's access to short-term, long-term, or permanent contraception, and even to information about those methods. Among these restrictions are:

- duties on imported condoms donated from abroad;
- limits on condom or vasectomy advertising;
- family planning clinics that link family planning to maternal-child health care, thereby being *de facto* "for women only;"
- legislation often precludes discussion of sexual issues among youth in formal educational or health settings;
- health professionals and concerned citizens at local and national levels are unwilling, untrained, or unable to speak out and to take action to promote improved policies and programs;
- most reproductive health programs fail to include policy advocacy training and support as a basic ingredient in staff orientation and training.

**8. Young Men Face Two Major Obstacles: Gender and Age.**
The conference identified young men as being particularly neglected by service providers. Even the few programs that do involve adolescents aim chiefly at young women, largely excluding their male partners. Most African teenage men are not well informed about sexuality, safe sex, condoms, and other contraceptives; many youth spread erroneous information to their peers and partners. Sex-role stereotypes, peer pressures, and sexual double standards play important parts in determining the sexual behaviors of young African men and women.

Though less likely to be targeted in communication and services, young men are more likely than young women to be sexually active, to have multiple partners, and to begin sexual activity earlier. On the other hand, the average young man appears less likely to receive information about sexuality and reproductive health from family members than young women, who learn from mothers or aunts. African parents rarely talk about sex in depth to sons.

Approaches need to be developed which reach youth in their own settings. Peer groups and peer counselors are a possible avenue. Youth centres which integrate health services with social and educational facilities provide a more comfortable and less threatening environment than clinics. As with men, sports

activities are a strong catalyst for reproductive health IEC interventions. School nurses can be trained to diagnose and treat STDs, provide pregnancy tests, abortion counselling, and referrals.

**9. The HIV/AIDS Pandemic has Provided an Incentive for Men's Commitment to Reproductive Health**

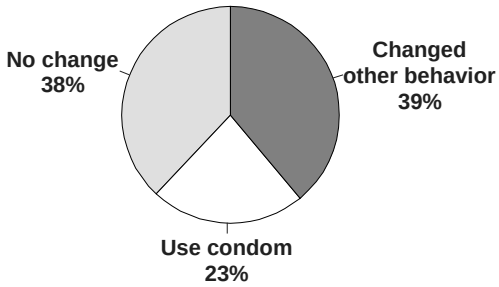
Men's participation in reproductive health has become a timely and global concern for many reasons, not least of which is the spread of HIV/AIDS. Perhaps more than any other factor, the explosion of HIV/AIDS and other sexually transmitted diseases in Africa has dramatically increased men's concern about reproductive health.

Before the pandemic, women were far more likely than men to die from unsafe sex because of the risks of pregnancy and childbirth as well as STDs; now unprotected sex can be lethal for men as well. Men's role as initiators of sex and potential users of condoms was stressed as a top concern of conference participants, who were also concerned about ways to integrate

HIV/AIDS prevention and treatment into communication activities. Concern for AIDS may, paradoxically, help increase men's positive role in sexual and reproductive health.

**Men Who Have Changed Sexual Behavior To Avoid AIDS**

*Zimbabwe, 1994*




Source: DHS Country report, Macro International

**10. Social Marketing Is a Powerful Means of Reaching Men.**

By using mass media through many channels (print, radio, TV, magazines) social marketing is more likely to reach men than clinic-based education. Condom advertising and marketing can promote use with casual partners and wives. Retail and pharmacy sales make contraceptive supplies available to more men. CBD distribution and sales, often man-to-man, increase men's access to condoms and condom counseling.

**11. Communication Between Partners about Sexual and Reproductive Health Is Difficult.**
Another pervasive barrier to men's positive participation is the perennial, global problem of male-female communication: traditionally, men and women are not comfortable talking about sexuality and contraception. Increasing the ability of all couples to communicate and cooperate in reproductive health and family planning--without limiting anyone's fundamental right to privacy, confidentiality, and choice--may be the most difficult challenge facing reproductive health service providers and communication experts.

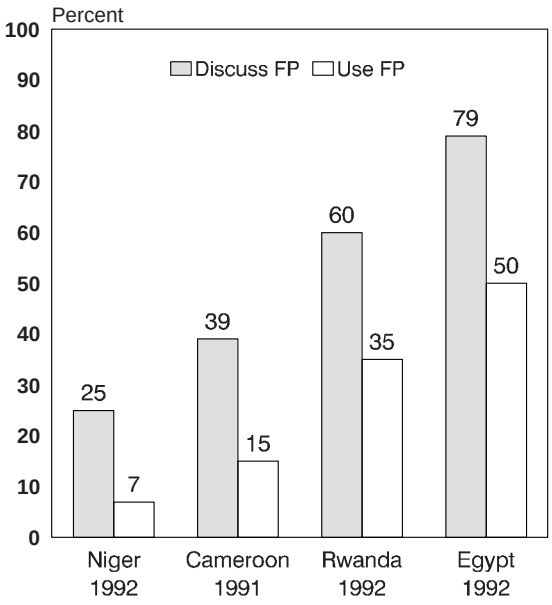
That profound challenge is even greater among the many African couples who are adolescents, refugees, unmarried, illiterate, or geographic-ally separated by employment or migration. It is exacerbated by many forms of prostitution in rural and urban communities—the relatively few condoms used in Africa are usually used only outside marriage. These and other obstacles to improving men's reproductive roles led to agreement on the basic objectives and expectations of the conference.

Many women are concerned, both as partners of men and as providers of reproductive health care, that increased involvement of men could in some cases have adverse effects on women. At the personal level, they want to be sure that men's participation in shared reproductive and sexual decision-making will strengthen, not threaten, couple communication and gender equity.

At a programmatic and institutional level, women want to be sure that devoting time, space, funding, or supplies to serving men will have the effect of increasing, not decreasing, services available to women. Programs must be designed with gender equity, women's reproductive rights, and women's health needs in mind. The conferees agreed, as stated in the Harare Declaration, that the reproductive and sexual health of men and women is inseparable, and that both partners must cooperate to stay healthy. Indeed, experiences in Africa to date indicate that increasing men's participation will almost always improve, not weaken, women's health and women's rights. In the great majority of programs reaching out to men, men want to involve their partners in sharing family planning decisions more than before.

Discussion vs. Use of Family Planning

*Percent of husbands who discussed FP with wives and used FP in previous year*




Source: DHS Comparative Studies, No.18, Macro International.

Produced by Family Health Services and the Ministry of Information, Oyo State, Nigeria, this scene from the video drama, *Eni A Wi Fun [To Be Forewarned]*, conveys the tension and difficulty of discussing reproductive health choices with one's partner.

## CASE STUDIES IN COMMUNICATION AND MEN'S PARTICIPATION

All countries face major obstacles in getting men involved in reproductive health, but there are now many countries in sub-Saharan Africa where experience has proved that men can be a positive force in improving family health. Evaluations of African programs show that addressing men's fears and concerns about family planning reduces their resistance to it.

Partner communication and social support are two key elements in starting and sustaining men's contraceptive acceptance. Six case studies were presented at the conference; each illustrates that both the interpersonal and broader social elements of men's participation can be strengthened by thorough research and well-planned IEC interventions.

The case studies were presented and discussed at the conference not to be simply copied, but to inspire participants to design their own innovative approaches. A number of participants did adapt elements of the case studies into their own pledges to further action and shared them on the final day of the conference.


The *People's Road Show* motivates men to consider family planning. Outdoor shows are regularly performed in association with the ZNFPC. This was one of three site visits attended by conference delegates at Domboshawa, 40 kilometers north of Harare.

# Ghana

GHANA HEALTH AND FAMILY PLANNING INFORMATION PROJECT* (September 1987 through April 1993)

### Project objectives for men

- To improve men's knowledge about, attitudes toward, and practice of modern family planning methods
- To mobilize religious and other traditional leaders to support the campaign

### Project description

Ghana's family planning campaign used a multistage and cumulative strategy to address both men and women. Phase One of the campaign focused on improving the interpersonal skills, image, and morale of service providers and on encouraging men to visit Ministry of Health clinics. Phase Two, addressed men's participation and countered rumors and misinformation about modern family planning methods. The campaign included two slogans, "Talk to Your Family Planning Advisors—They Care" and "Choose Family Planning with Your Wife."

*Awo Dodo* (*Too Many Children*), the campaign theme song, became a national hit. The campaign was launched in all districts at *durbars*—traditional town meetings— where chiefs, religious leaders, and government officials endorsed the campaign. Included in these launches were football and draughts competitions followed by men's discussions in communities and workplaces. Ample time was provided the men to ask any questions about family planning.

### Communication outputs and activities

Nationwide Media: motivational posters; family planning method booklet; three radio programs ("Radio Doctor," "Health Update," and "Family Affair"); television drama ("Our Concern"). Community activities: *durbars*, sports competitions, boat regattas, football matches, and raffles. Printed Materials: posters, leaflets, billboards, badges, T-shirts, shopping bags with family planning messages. Audiovisual Media: video dramas ("The Last Pregnancy"and "The Resolution"), audio cassettes with a family planning message, and the theme song *Awo Dodo*.

### Research and evaluation

- Household surveys and focus group discussions.
- Special studies including a recall and comprehension study and a cost-analysis study.
- Analysis of clinic service statistics.

### Campaign impact

After 19 months of intensive campaigning in three regions, 96 percent of men had heard the theme song and had seen the campaign poster. Men and women exposed to the campaign were significantly more likely to take a family planning action than those who had little or no exposure. Among men exposed to the campaign, 47 percent had discussed family planning with their partners, and 26 percent said that they or their partners were using a modern contraceptive method. Men were more likely than women to talk to a partner (42 percent *vs.* 25 percent) and begin contraceptive use (11 percent *vs.* 4 percent) as a result of the campaign.

### Collaboration and support

Ghana's Ministry of Health/Health Education Division; technical assistance provided by JHU/PCS with funding from USAID.

* Case study presented by Mary Arday-Kotei, Health Education Unit/Ministry of Health, Ghana.

## Ghana

DADDIES' CLUBS* (IPPF, USAID)

### Project Activities

Before 1980, Ghanaian men were "unfortunately de-emphasized in family planning programs," said Dr. Addo, Director of Programs of the Planned Parenthood Association of Ghana (PPAG). So, to increase the number of men using family planning methods, and to encourage them to support their partners in practicing family planning, the PPAG developed "Daddies' Clubs." At these clubs male employees from 17 to 45 could gather for family planning information (and limited services) during leisure periods at places of work and other institutions.

PPAG field staff worked in partnership with local and group leaders to conduct studies of men's interests and attitudes and to organize discussions about sexual and reproductive health to address men's specific concerns. Many men use the clubs as their main source of contraceptives; it is common for men to bring their partners to the clubs or pick up pills for them. Some men also come to the clubs for counseling on infertility. Initially funded by IPPF in three of the seven regions where PPAG operates, the clubs were expanded to all regions of Ghana in 1996, with USAID funding.

### Lessons Learned

PPAG evaluation of the Daddies' Clubs found that:

- Ghanaian men believe the discussions they hold at the clubs do provide a useful source of information and peer support about reproductive health; they particularly liked the "feeling of belongingness" [*sic*] among the men, which is crucial to "keeping the groups going," and the clubs' recreational activities (football, table tennis, card games);
- Targeting men has led to increased acceptance and practice of family planning (although no figures were provided in this presentation);
- Men share information from the clubs with people in their own communities;
- More information is needed to promote long-term and permanent methods, particularly vasectomy--"especially among group members whose family is definitely complete;"
- More emphasis is also needed on sexuality, particularly gender roles and relationships;
- Staff need training in sexuality counseling.

In 1997, PPAG will expand sexuality training and will open, for the first time, three men's clinics to specialize in the full range of reproductive health services for men.

* Case study presented by Nii Adote Addo, Planned Parenthood Association of Ghana.

## Kenya

THE VASECTOMY PROMOTION PROJECT* (July 1994 through January 1995)

### Project objectives for men

- To improve attitudes toward and knowledge about vasectomy among Kenyan men
- To increase the number of clients requesting information on vasectomy
- To increase the number of vasectomies performed

### Project description

The Vasectomy Promotion Project was initiated to complement a concurrent AVSC funded project coordinated by Innovative Communication Systems aimed at improving the quality and quantity of vasectomy counseling and services. Guided by an advisory group of key policy-makers and representatives from family planning organizations, the Vasectomy Promotion Project sought to accomplish its objectives through a mass-media campaign directed primarily at men and secondarily at their spouses and medical practitioners. Unfortunately, the national radio and television broadcasts were not aired due to the Kenya Broadcasting Corporation's concerns that airing information on vasectomy would produce a public backlash. A private television company— Kenya Television Network— carried the broadcasts without any problems, although limited to the Nairobi area. To reach rural audiences, a local mobile cinema company broadcast the television and radio spots in its coverage areas. Newspaper advertisements were also included in four daily newspapers, becoming the primary communication channel for the project.

### Communication outputs and activities

Radio and television spots promoting clinics which offer family planning information and services for men; television spots with testimonials of satisfied users; a radio forum; an interview on a radio talk show; newspaper advertisements with coupons; workplace motivators and film clips; flyers, booklets, leaflets, and posters.

### Research and evaluation

- Monitoring of service statistics in six vasectomy sentinel sites over a 12-month period.
- National IEC Situation Survey.

### Campaign impact

The number of vasectomies performed increased by 125 percent during the campaign. Results from a National IEC Situation Survey conducted midway through the campaign found that 42 percent of male newspaper readers had seen the vasectomy advertisements. Of all the methods in the survey vasectomy awareness increased the most.

### Collaboration and support

Innovative Communication Systems; AVSC International; National Council for Population and Development; Division of Family Health/MOH; Family Planning Association of Kenya; Family Planning Private Sector; International Population Health Services; Christian Health Association of Kenya; Kenya Institute of Mass Communication; Pathfinder; The Population Council; UNFPA; University of Nairobi; and Kenya Medical Association; technical assistance provided by JHU/PCS with funding from USAID.

* Case study presented by Dan Odallo, Johns Hopkins Population Communication Services, Kenya.

## Kenya

MYSTERY CLIENT STUDY: THE VASECTOMY PROJECT*

*How Are Men Treated as Family Planning Clients?*

### Study Objectives

This 1993 study by AVSC International and JHU/PCS sought to find out how men were treated by receptionists and counselors at seven family planning clinics in Kenya. The study addressed the growing awareness of the need to involve men in family planning, and because little is known about the quality of care for men in family planning (other than anecdotal evidence that men faced difficulties in seeking information, particularly about vasectomy). She study also focused on how well a man, who may be new to or feel unwelcome in clinics, is received and counseled.

There is no "quality of care" index for men. The Kenya study was intended to evaluate the quality of reception and counseling. Lessons learned from the study would be applied to training clinical and non-clinical staff to provide better information and services to men. The "mystery client" technique was used because it has proved effective for evaluating service delivery; it avoids bias resulting from the direct observation of real client-provider interactions.

### Study Description

Four men were trained to pose as family planning clients: two in their twenties, two in their forties, and all ethnically similar to the men in the areas around the seven clinics. The clinics were selected as representative of geographical areas and different service organizations; each organization was made aware of the study, but not of the individual clinics chosen.

Each clinic was visited twice in one month: once by a younger man, once by an older man; each said he had three children and wanted family planning information. After each visit, the mystery clients completed questionnaires and oral debriefings.

### Study Findings

- **Counseling**

Mystery clients reported different reactions within and among clinics. Counseling was done in private in only half the 14 visits; in the other half, the counseling was in public or frequently interrupted. In only seven visits was the counselor consistently polite and friendly. In five visits the counselor was friendly some of the time. In one of the visits staff made fun of the client behind his back.

On the positive side, although the clinics were busy, men did not have to wait long for counseling (although one was kept waiting for over an hour while women who arrived after him were served first). Most receptionists were pleased to see a male client; one tried to counsel the mystery client at the front desk while helping other clients.

- **Lack of Information for Men**

Though many clinics had ample IEC material for women, there was rarely any material for or about men. Just over half the counselors were positive toward the male clients and vasectomy. In 10 of 14 visits, counselors were generally knowledgeable about most, but not all, aspects of vasectomy and other family planning methods; one counselor told of a very satisfied client whose sexual relationship had improved after vasectomy.

* Case study presented by David Wilkinson, AVSC International, Africa Region.

- **Discomfort with Men and Vasectomy**

Counselors seemed to have less understanding of vasectomy than of tubal ligation--which is to be expected when vasectomy is used so rarely. Four counselors described the vasectomy procedure incorrectly; half could not answer some basic questions (*e.g.*, four did not know what happens to the sperm).

All but one provider involved (a male receptionist) were females. In half the visits, counselors were ill at ease dealing with a male client. A number of providers were clearly uneasy dealing with vasectomy, a male client, or both, and some were embarrassed using words for male genitals. Three women providers tried to discourage the client from having a vasectomy; one receptionist even chased a mystery client away, hitting him with a Bible! One of the mystery clients said he began to feel he should be called a "misery client" instead.

## Study Conclusions

- **Dangers of Gender Stereotyping**

The study illustrated the importance of avoiding the trap of gender stereotyping. Providers should remember that some men do care about the reproductive health of their partners (as well as their own) and are positive about using family planning. Sometimes women may be "the problem," opposing family planning or vasectomy for their clients or their male partners.

- **Need for Male Knowledge, Attitude, Practice (KAP) Research**

Whatever the few studies like this one show, one definite conclusion is that more research is needed into both men's and women's attitudes toward sexual and reproductive behaviors. We also need to recognize that men (and women) receive most information about sexuality and reproduction from peers, not from professional providers.

- **All Providers Need Training to Serve Men**

At all clinics, and presumably in community-based programs too, <u>all</u> staff--from janitors and drivers to receptionists and counselors--need training to work with men. The best training and evaluation programs should involve satisfied clients, not only in providing feedback to providers, but also as peer counselors, men trained to talk with other men about sexual and reproductive health behaviors. Male volunteers who have been particularly trained to explain vasectomy, would be very helpful.

- **Main Message**

The major "take-home" message of this study was that all cooperating agencies providing services need to move toward a new view of involving "men as partners" (the name of AVSC International's male involvement initiative). Men should be partners in sharing responsibility for sexual and reproductive decision-making and in parenting.

# Nigeria

MALE REPRODUCTIVE HEALTH COMMITMENT* (IPPF)

### Project Background

DHS surveys revealed that although Nigerian men have better educational and economic opportunities than Nigerian women, nearly 13% of the men oppose family planning, mostly for what they called "religious reasons." In 1991, the Planned Parenthood Federation of Nigeria (PPFN) began a major effort to design services to increase men's participation. Three integrated programs focused on men.

### Project Goals

The goals of this initiative were to analyze why so few men used modern contraceptives and family planning services, to advocate improved programs for men (particularly uneducated men), and to institute a variety of men's services, particularly in the workplace. PPFN formed a national advisory committee, designed various male initiatives, and held interviews and focus group studies to adjust project designs before and during implementation.

### Male Family Health Services (AVSC)

PPFN began this program to increase knowledge of vasectomy and offer vasectomy services for the over 40% of men who wanted no more children. Initially budgeted for $1.1 million over three years, this project was cut back because of decertification by the U.S. government, under which funds intended for government projects were frozen.

### Integration of Modern Family Planning into Traditional Health Practices (Pathfinder)

After careful planning with government officials, experts in traditional medicine, and traditional healers themselves, this sensitive and innovative PPFN project was designed using a baseline survey of leaders at all levels and in communities. PPFN then trained newly recruited traditional healers in reproductive health, including family planning, safe motherhood, child survival, and aseptic clinic management. They also updated the skills of other healers in two Nigerian states. In Year Two, PPFN trained other traditional healers.

A total of 287 healers have been trained and have achieved several specific service delivery outputs; 75% of 286 trained healers were men. Project coordinators and their assistants supervise healers, keeping monthly and quarterly reports and using regular meetings to discuss issues arising from project implementation.

### Lessons Learned

The project met its main objective, proving that modern family planning could be integrated with traditional health care. PPFN proved that healers could be trained in modern health practices, including aseptic technique; were able to increase use of modern instead of traditional contraception; and, would refer clients to clinics for services.

The program's most difficult problem is the high price of commodities, mainly condoms, and the obstacles to cost-recovery. Contraceptives are already heavily subsidized, and healers want to have 25% discounts, so pricing commodities is a persistent management and sustainability issue. PPFN overestimated how much the use of barrier methods would increase, partly because of pricing issues and partly because traditional healers were not accepted by modern health professionals.

* Case study presented by Dr. A. B. Soulaiman, Planned Parenthood Federation of Nigeria.

# Zimbabwe

MALE MOTIVATION AND METHOD EXPANSION PROJECT* (1991 through 1994)

### Project Objectives for Men

- To increase the awareness knowledge and approval of long-term and permanent contraception among sexually active men ages 18 to 54
- To promote joint decision-making on the use of family planning methods among couples
- To increase the number of couples using long-term methods to space births and limit family size

### Project Description

Building on lessons from the first campaign, the Zimbabwe National Family Planning Council (ZNFPC) launched a second male motivation campaign—The Male Motivation and Method Expansion Project. The campaign's theme was "Family Planning: It's Your Choice," which challenged men to take responsibility for their families by adopting a family planning method. Men ages 18 to 54 were the primary audience.

The 6-month campaign was divided into three brief phases. The first asked men, "Do You Have a Dream?" and explained how family planning could help make the dream a reality by limiting families. The second phase advised men to "Play the Game Right" by consulting a service provider about the various contraceptive methods. The third phase encouraged men to include their partners in family planning decisions with the slogan, "It Takes Two to Plan a Family."

The idea of winning was reiterated throughout the campaign, as it was thought to convey a virile image that would be appealing to men and prompt them to take action. Slogans promised to show men how to "win the family planning game by reaching the goal of a small family with the help of their teammates (spouses/partners) and coaches (service providers)."

### Communication Outputs and Activities

The second campaign included radio, television, newspapers, magazines, football matches, community mobilization events, live dramas, and musical shows. Mass-media broadcasts including two weekly radio dramas: "I Told You So" and "You Will Regret," in which male characters encourage men to plan their families; two television and 10 radio spots; posters, pamphlets, newspaper articles with slogans like "It Takes Two" and "Be a Man Before You Are a Father;" and community events—soccer matches, puppet shows, dramas, family festivals, performances by popular music groups, banners, posters, bumper stickers, badges, T-shirts, and caps.

### Research and Evaluation

- *Household Surveys* of both men and women conducted before and after the campaign;
- *Client Interviews* with clients who started or switched methods during the campaign;
- *Service Statistics* over an 18-month period from 23 facilities offering long-term and permanent methods.

### Campaign Impact

The campaign reached a large majority of adults in the five campaign areas: 88 percent were exposed to at least one campaign material or activity. Radio reached the most men, followed by print materials. The intensity of men's exposure was greater than for women. Men cited newspapers, magazines, and the sports events as their major sources of family planning information. Women cited the radio drama and motivational talks as their main sources of information.

* Case study presented by Godfrey Tinarwo, IEC Unit, Zimbabwe National Family Planning Council.

Exposure to the campaign was associated with a rise in the use of modern contraceptives. People exposed to three or more campaigns were 1.6 times more likely to use a modern method when controlling for gender, age, marital status, residence, education, and socioeconomic status. Before the campaign, demand for contraceptives was declining, perhaps because of an increase in contraceptive prices. The media campaign reversed this trend, and contraceptive demand increased, especially for long-term methods. The proportion of women who reported discussing family planning often with their spouses or partners increased from 37 percent before the campaign to 57 percent after the campaign.

An unexpected result after the campaign was that men were more likely to believe that they *alone*, not jointly with their spouses, should be responsible for making reproductive decisions. This finding suggests that the campaign's reliance on traditional masculine images may have reinforced stereotypes about men's decision-making authority and blurred the campaign's message on the value of joint decision-making.

### Collaboration and Support

Zimbabwe National Family Planning Council; technical assistance provided by JHU/PCS with funding from USAID.

## OUTCOMES

Conference participants brainstorm about men's issues.

Most of the conference was spent with the participants in active discussion about challenges to men's participation and strategies which respond to those challenges in concrete, realistic ways. They met in plenary sessions, in small working groups or around the hotel in more informal settings during breaks and in the evenings. As a result, the conference produced a number of tangible outcomes across a broad spectrum of issues and approaches. This section summarizes the following outcomes:

- ***Working groups*** *challenges, strategies and recommendations*;
- ***Participant pledges*** to initiate activities on his or her return home;
- The ***Harare Declaration***, and,
- Launch of the ***Challenge CUP: Sports Initiative***.

# Working Groups

Among the working groups, there was consensus on a number of cross-cutting issues. They agreed that recognizing men's diversity in all its dimensions--in age, education levels, socioeconomic status, family situation, work environment, etc--and deciding how to reach and serve the needs of these different categories of men are the communicators' biggest tasks. Programs must use diverse channels of communication to reach men at home, at work, at religious and social events, in schools and community centers and whenever they receive educational or commercial messages.

Conference participants identified five key sub-themes which should be given consideration in the design, implementation and management of effective communication programs for men. Five working groups were organized around each sub-theme and met on three afternoons:

1) Men as **different audiences**
2) **Young men** and their particular concerns
3) **Integration** of IEC for men into reproductive health
4) **Cultural challenges** to men's participation
5) **Sustainability** of men's programs.

At a minimum, all men need reproductive and sexual health education; most men will also benefit from individual counseling (and, when appropriate, couple counseling). Additionally, many men will require clinic services for physical exams, diagnosis and treatment of STDs, further counseling, contraceptive supplies, and, as they complete their family, the choice of long-term and permanent methods. Like women, men should have a free and informed choice of whether to use a contraceptive method and, subject to his partner's agreement, whether to have a child. This standard package of care is a "common denominator" for all men in all cultures.

**Information, Education, and Communication:**

- *more and better IEC materials* directed towards men;
- more messages which support the idea of *increased communication between partners*;
- and *new and updated training curricula* to address the specific issues of counseling men.

**Interpersonal communication and service delivery:**

- *more men recruited and trained* as service providers—whether as CBDs or in clinics or in the workplace;
- better support from private practitioners, PVOs, and NGOs to offer services to men (every employer can provide reproductive health education and referral to services as part of their employee benefits);
- a *greater variety of service approaches* which respond to men's needs.

**Policy and Advocacy**:

- better advocacy among leaders to support laws, policies, and funding that ensures that all young men and women receive basic education about reproductive and sexual health and have better access to services.

What follows are the **Challenges** and **Strategies and Recommendations** of each of the working groups, excluding the cross-cutting issues mentioned above.

Working Group I

# Men as Different Audiences

To increase men's participation in reproductive health, communicators must first see men as many different audiences (see table below) and address them with different messages. While segmenting these varied messages is important, an underlying purpose of all such IEC remains to encourage men, either individually or as partners in couples, to communicate about sexuality and family planning, and to ensure that both partners share equitably in reproductive health decision-making.

**Segmentation of Men's Characteristics, by Age**

| Age<br>20 - 35 years | Age<br>36 - 45 years | Age<br>46+ years |
|---|---|---|
| • Potential ***child-spacers***—<br>unmet need for FP, especially temporary methods | • Potential ***limiters***—<br>unmet need for FP, especially long-term or permanent methods | • Unmet need for ***permanent contraception***, and access to vasectomy information and services |
| • High desire for children | • Married, usually with desired number of children | • Married, usually with desired number of children |
| • May have little communication with partner | • May have little communication with partner | • May have little communication with partner |
| • Concerns about unsafe abortion, need for abortion counseling with partner | • Potential polygamists, frequently with prostitutes (high risk of HIV/AIDS and STDs) | |
| • Needs work, income, and housing | • Economically established | • Economically established |
| • Highly mobile, may do migrant labor | | |
| • Have ambitions, looks to the future | | |
| • Can be reached through peer group, workplace education, clinics, mass media, and role models | • More conservative than younger age groups | • Traditional values |
| • Media conscious | • Can be reached through peer groups, workplaces, clinics (accompanying wife and children), media, and men's clubs | • Can be reached through peer groups, workplaces, media, and men's clubs |

## Challenges

Currently, few men of any age, or cultural or geographical group, have access to information in their communities, at clinics, or on the job, because reproductive health programs are tailored to women's needs. Typically, this means that:

- More women than men are recruited as service providers;
- Clinic hours and home visits are not convenient for working men;
- Staff are not trained to understand men's reproductive health needs; and
- IEC materials are not available for men.

As a result, men often have little respect and few positive attitudes toward services and service providers even though survey results show they are supportive of the *idea* of family planning; young men are usually the least welcome and the least comfortable visiting clinics.

## Strategies and Recommendations

Several strategies were suggested to bring information and services to different groups of men.

### *New Communication Strategies*

- Produce IEC materials for men which motivate them and their partners to seek services together and share information and decision-making;
- Improve the image of providers to male (as well as female) clients;
- Test innovative communicators, such as traditional healers and birth attendants, peer counselors, marriage counselors, school counselors, sports teams (see Challenge Cup below), or male elders;
- Address the issue of "Sugar Daddies" and irresponsible male sexual behavior in IEC campaigns. Men should be sensitized to the consequences of their behaviors (unwanted pregnancies, school dropouts, unsafe abortions, STDs/HIV). Consider the theme: "It could be your daughter."
- All campaigns should emphasize the dual use of condoms for family planning and disease prevention and all services should combine condom counseling and resupply with education and referral for STD and HIV treatment.

### *Communication and service delivery*

- Integrate reproductive health into the curricula and at schools, vocational training institutions, universities, and in other youth and adult education programs;
- Redesign training curricula to address the special issues of counseling for different audiences of men--single men, men in couples, abusive men, young men;
- Recruit men as providers (or reassign men to work more with male clients).
- Create male-friendly CBD and EBD programs.

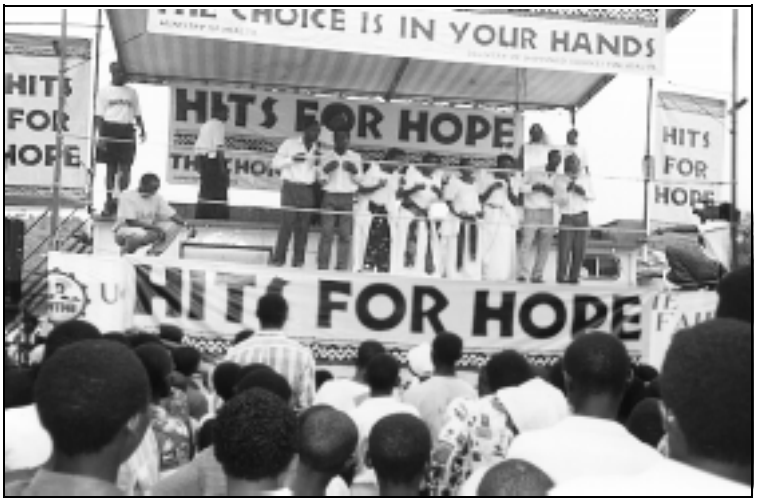
## Challenges

Young men—and young couples—require particular attention and special programs. Young men are usually neglected in typical reproductive health activities because those programs are female-focused. Young men are particularly unwelcome because their sexual activity is not sanctioned, is sometimes even illegal. Services are not yet geared to meet the needs of youth: school-based programs are rare,
as are youth-friendly health clinics. While some young women may receive basic information about reproductive health from family or health workers when they menstruate or become pregnant, most young men do not learn from the health system but from peers, whose information is often inaccurate.

## Strategies and Recommendations

### *Information, Education, and Communication*

The group recommended a wide range of strategies to reach youth who are known as a difficult audience to reach. The key was identifying their needs, their habits, the media they use and the places where they can be reached




Young people in Uganda gather around the *Hits for Hope* stage as their peers perform songs they composed about sexual responsibility.

Self-esteem, confidence, responsibility, self-respect, and the power to say no are key issues for youth which need to be addressed through IEC. To reach youth, campaigns need to reach youth where they meet: in schools, religious organizations, discos, pool halls, video arcades, on the street, in the marketplace, at sports venues, and during agricultural shows and local fairs.

Media that have been used successfully to reach youth include radio variety shows, local *popular theater,* peer education networks, youth center activities (social, educational and recreational), telephone hotlines, newsletters, and traveling road shows.

### *Advocacy*

The group re-iterated the need for strong advocacy to support laws, policies, and funding which ensure that all boys and girls receive basic education about reproductive and sexual health (in- and out-of-school) and that they have access to contraceptive information, services and supplies. The group supported legalization of medical abortion; the provision of post-abortion care for young women recovering from unsafe abortions, including counseling for their male partner; and passage and enforcement of laws requiring a minimum age of 18 at marriage. They want to see improved school policies on pregnant students and partners, allowing students to complete their schooling, and counseling and services to encourage sexual responsibility, sexual health, family life/parenting skills, and to discourage unplanned pregnancy.

### *Communication and Service Delivery*

In the provision of services and IEC materials for youth, the group recommended that reproductive health organizations should:

- Increase accessibility and convenience of services to youth;
- Ensure youths' privacy under any setting;
- Link services to schools or youth centers wherever possible;
- Provide special training to staff on adolescent counseling in reproductive health;
- Provide (or refer to) post-abortion care for young women and counseling for their partners; and
- Train peer counselors to talk to other young men and women.

### *Community Participation*

- Community leaders can encourage parents to learn about reproductive health with their children;
- Leaders can encourage and support later marriage; and
- Communities use local music and drama groups to communicate their key messages.

A ZNFPC Provincial IEC Officer distributes condoms to eager young men.

Working Group 3

# Integration

## Challenges

IEC, whether for young or adult men, must be integrated into a wide range of community and work-related activities. Men who need family planning counseling and supplies are not sick; they are much less likely than women to go to a clinic or CBD for help. But men could receive this information where they work or play (at their jobs or at sports, social, or cultural events). Messages integrating family planning and STD prevention are also vital in reaching men, many of whom are less concerned about avoiding pregnancy and more concerned about avoiding STDs and HIV than women are.

## Strategies and Recommendations

The Integration working group drew attention to the lack of effective IEC and counseling for men in the media, at the community level, and in clinics, recommending integration of:

- Male-focused IEC into different communications channels; and
- Reproductive health and STD services into traditional family planning programs.

Various approaches to integration are possible, including advocating new national government and broadcasting company policies as well as community education and health service delivery policies. The goal is to ensure that IEC and counseling aimed at men include both family planning and STD prevention.

### *Integrating IEC for Men into Health Services*

Reproductive health organizations should:

- Provide comprehensive, high-quality reproductive health services to all men;
- Integrate IEC materials and counseling tailored to men's needs and concerns;
- Involve *district* management in all phases of program design and implementation;
- Include IEC materials and counseling methods for men in all training of all staff;
- Adapt the STD assessment instrument to local communities and retrain staff in its use;
- Link STD/HIV risk assessment and the syndromic approach to family planning counseling;
- Promote dual benefits of condom use throughout all agencies and programs; and
- Establish counseling policies and follow-up procedures for notifying partners of STDs/HIV exposure.

### *Advocacy: Integrating IEC for Men into All Reproductive Health Communications*

A series of advocacy objectives at the policy and program levels were recommended.

Policy level—Government ministries, such as Health, Education, Family/Social Affairs, Information, Labor, Agriculture, and others, should work together to coordinate the promotion of men's participation in reproductive health in all their health-related activities.

Program level—Mass-media managers and "gatekeepers" should integrate reproductive health for men into all appropriate communication activities and that managers mobilize community and religious leaders to integrate reproductive health IEC for men into community activities such as community meetings, bazaars, sports events, beer halls.

Working Group 4

# Cultural Challenges

## Challenges

Communication programs can play a central role in changing the social and cultural norms that work against reproductive health. This group discussed cultural barriers to the use of contraception and safe sex, and listed the following cultural challenges to involving men in reproductive and sexual health:

- Lack of communication and shared decision-making in couples;
- Breakdown of traditional family and community systems;
- Traditional respect for large families and for polygamy;
- Anti family planning interpretations of religion;
- Gender preference for male over female children;
- Myths about modern family planning as unhealthy, unreliable or immoral;
- "Double standard" tradition allowing men to have multiple partners;
- Perceptions of family size as a reflection of male virility;
- Perceived need for child labor;
- Likelihood of need for economic support in old age; and
- Family planning as a "foreign" or "sinful" practice.

The group identified the difficulty men and women face discussing sexual and reproductive health matters and coming to mutual decisions, as the single most important challenge to involving men. Barriers to interpersonal communication includes embarrassment, social taboos, or concern over how others perceive them. Men fear being perceived as weak, especially in light of traditional roles and expectations that equates male strength with autocratic behavior.

## Strategies and Recommendations

Information, education, and communication aimed at men and couples must emphasize the benefits of improved partner communication. Benefits accrue to both the man and his family if all family members share responsibilities and are better cared for, healthier, and happier. Partners' communication can alleviate misunderstandings, fears, jealousies, and suspicions troubling relationships. Cooperation may reduce multiple partners and the resulting transmission of STDs/HIV.

Men can be helped, through peer, CBD, and provider counseling and education, to understand the advantages to themselves and others of partner communication. This will allow them to understand issues fully and clearly when making any health-related decisions. They learn that "a changing world requires changing attitudes and behaviors." They can learn how communication builds trust, understanding, and cooperation between spouses, and can even improve the quality of a couple's sexual relations.

The working group generally agreed that the key messages for men should focus on the benefits of smaller families. IEC can explain the traditional barriers to smaller families and show how they may no longer apply, as well as show the negative socio-economic and health consequences of large families. With fewer children:

- Fathers are more able to fulfill their familial and financial responsibilities;
- Men's health and that of their wives and children may improve;
- Healthier and better educated children can care better for their fathers in old age;
- Fewer children will mean greater inheritances for each;
- Smaller families appear more "modern," fit the modern way of life.

### *Communications Strategies*

Policy level—Governments and the private sector provide an environment for shared, free, informed choice in sexual and reproductive decision-making

Program level—Messages should remind men of their interdependence with women, both in economics and in health sensitize men (and women) and highlight the importance of partner-to-partner communication ("two heads are better than one", "united we stand, divided we fall" or "one finger cannot pick up a stone"). The group also suggested that IEC programs explain the consequences of gender-preference for sons on family life and family health, promote condom use, and explain the risks of having sex with multiple partners.

Community level—Communication channels include traditional opinion leaders, chiefs and village councils, religious leaders, traditional ceremonies and social networks, local languages, traditional marriage counselors, drama groups, CBD agents (especially men), and clubs and associations. Local communication strategies should include sensitization meetings and training of trainers for local community leaders to become advocates; group communication should make the best possible use of community mobilization activities like celebrations and festivals, sports events, and road shows.

### *Advocacy*

The group had strong advocacy recommendations: Leaders at all levels should support men's participation in reproductive health; district and community health teams should appoint or hire a community outreach organizer to involve the community in person-to-person and small group discussions on men's role in reproductive health. Governments and cultural and community leaders should advocate and support women's rights and discourage cultural norms preventing the advancement of girls and women (e.g. providing equitable access to basic education for young women and young men).

Legislative strategies were also recommended. New laws or changes to existing laws are needed to encourage men's participation in family health, and to discourage practices (like polygamy) harmful to women and girls. The group suggested that lawmakers pass equitable maternity and paternity laws to encourage men to be more involved with child care, and to make child support mandatory; that they institute new child benefit laws discouraging large families (*e.g.,* cap child benefits at four children); that they ban destructive cultural practices such as inheriting wives, sharing wives, and female genital mutilation; and that they pass equitable laws regarding spousal consent to contraception-- consent should either be required of both husband and wife or of neither partner.

Working Group 5

# Sustainability

## Challenges

Men's programs can best be sustained in the long run when they use cost-recovery methods. Many steps can be taken to help ensure lasting, high-quality programs, but few programs will survive, no matter how well designed, if they do not move towards more effective cost-recovery. Imaginative efforts, both reported on and planned at Harare, have been designed to persuade men (who are more likely than women to be able to afford it) to pay for reproductive health care.

This working group focused on the question, "How can men understand and accept reproductive health as a way of life?" They believed the primary obstacle to men's continuing use of and support for reproductive health services is that many men do not yet realize that sustained, life-long, reproductive health behaviors are essential to *all* adult health, much like proper immunization, nutrition, and hygiene. They are not simply options to be used occasionally.

## Strategies and Recommendations

This working group considered three levels of sustainability as important: policy support, financial sustainability and community commitment.

### *Policy Support*

They reiterated the need for advocacy at all levels of government and community. They stressed the need for good training of trainers, for curriculum revisions, quality control, and for monitoring and evaluation of all interventions.

The group stressed that all development programs that involve substantial numbers of men (such as schools, workers' education, agricultural extension programs, vocational training, military training, and prison education) should agree to include regular reproductive health education.

### *Financial Sustainability*

The group agreed that national leaders (presidents, vice-presidents, Ministers of Health, and other national figures) should commit funds to integrating reproductive health for men into existing health programs; should increase funding for research into male contraception and male reproductive health knowledge, attitudes, and practices; and should lower or eliminate taxes and import duties on contraceptives, or provide subsidies for contraceptives. They also agreed that family planning organizations should advocate a private-sector role in men's programs.

### *Community Support*

At the community level the group suggested that family planning organizations should actively involve the whole community in the design, planning, and implementation of men's reproductive health activities. Public education could include leadership seminars, discussions by men's groups; community and religious leaders should speak out for men's participation in reproductive health. Communities should provide funds, land, buildings, and volunteer labor for men's programs; communities should share in costs (along with fees for men's services); men in each community should play a leading role in activities that will earn money to support men's reproductive health services.

# Participant Pledges

Mrs. Joyce Kadandara, World Health Organization representative, calls for gender equal reproductive health.

On the final day of the conference, participants pledged to work toward increasing men's participation using the communication and advocacy strategies discussed in Harare. These pledges provided an innovative, relevant and action-oriented bookend to the participants' challenges that helped frame the discussion at the outset of the conference. Participants submitted objectives, target audiences, impact indicators, costs, and timelines. They worked individually or in teams. Twenty-five pledges presented at the conference are in the Appendix.

These pledges demonstrate a practical, varied, and innovative range of activities, which promise to build major men's participation components to be copied and expanded to reach large numbers of men. The most common feature of the programs envisioned in these pledges is information, education, and communication, using both mass-media campaigns designed to reach men and couples, and print materials to motivate individual men. Equally important are plans for advocacy—persuading high-level policy makers and program managers to increase communications and services for men and for couples. About half the pledges are related to ongoing programs, and half to new programs.

About one-third of the pledges are national in scope. For example, a leader in Ethiopia's National Office of Population pledged to develop nationwide programs for men's participation in both the National Population Plan of Action and the National IEC Strategy. A pledge by the director of Zambia's Information Services called for a national effort to produce IEC programs for men to encourage them to use Zambian reproductive health services. The South African Department of Health pledged to coordinate a national effort to involve all its units in men's participation activity planning. In contrast, other pledges focussed on more specific target groups and narrower goals. A Tanzanian trade union official pledged to expand an existing "Male Motivation Program" offering reproductive health services at the workplace by increasing sustainability through both employers' and workers' contributions. A leader of the Presbyterian Church in Cameroon will design a campaign linking new men's-participation IEC and counseling with existing church-sponsored health care, evangelism, and church celebrations. The Presbyterians, he pledged, will train thousands of lay church workers to counsel men throughout Cameroon.

Some pledges focus on specific tasks, such as increasing research activities (*e.g.,* Senegal's pledge to measure the effects of improved quality of care for men on their frequency of visits); expanded fund-raising (the South African Planned Parenthood Association's new Task Team will increase support for its men's participation program); or using the media, sports, and other cultural events to promote reproductive health to men (the Ghana Ministry of Health effort). The wide range of pledges demonstrates the importance of varying approaches to men's participation—and the value of sharing lessons learned between nations. Every participant's pledge included emphatic statements about the importance of hearing about other countries' experiences in formulating their own plans.

As a follow-up to the Harare conference, all participants will report to JHU/PCS on the progress they are making toward fulfilling these pledges. Progress reports will be collected and disseminated by the JHU/PCS Men's Participation Task Force as part of its ongoing monitoring and evaluation of men's participation campaign.

# Challenge CUP: Men's Reproductive

*The Men's Sports Initiative Challenge CUP* was announced by Johns Hopkins Center for Communication Programs. The Challenge CUP (for ***C****aring* ***U****nderstanding* ***P****artners*) is a program of matching grants to African organizations involved in promoting reproductive health to men through sports. The goal is to build on sports' mass appeal and existing infrastructure in Africa to encourage and reinforce men's active participation in family planning and the prevention of HIV/AIDS/STDs; to expand interpersonal communication among team members, their families, and their friends about acceptance of family planning and safe sex practices; and to increase the use of family planning methods. Matching grants of up to $50,000 for each of two countries will be awarded to government or private/commercial organizations, or NGOs, such as sports federations, that present proposals which best make use of local organizations and resources to foster the goals of the *Challenge CUP* initiative.

### Project Objectives

- To demonstrate an increased and sustained practice of HIV/STDs-preventive measures among sports team members, their families, and the wider society of men;
- To expand interpersonal communication among team members, their families, and their friends about acceptance of family planning and safe sex practices;
- To encourage more couples in the wider society to talk with each other about acceptance of family planning and safe sex practices;
- To increase the use of family planning methods.

### Key Project Activities

The Initiative will comprise a variety of activities at three levels:

International level—link messages about reproductive health and HIV/AIDS/STD prevention with high-profile national and international soccer matches.

National level—involve premier league teams, testimonial support from high-profile players, and will advocate with governments and appropriate organizations for more men's participation programs.

Community level—cooperate with local teams, coaches, and other youth-serving organizations to build programs for young men and women to provide information and counseling on issues of sexual responsibility and disease prevention.


Advertisements for the *Challenge Cup* featuring popular soccer players appeared in newspapers and magazines in Zimbabwe. In this ad, "playing the game right" meant practicing family planning with your partner.

## The Harare Declaration

Building on the concept that advocacy is fundamental to men's participation activities at every level, participants ended the conference, not only with individual and team pledges, but also with a public declaration committing themselves to "efforts to build upon the important work of many African governments and NGOs, as well as donor agencies, to promote men's responsible and equitable role in reproductive and sexual health." (See page vii for the full text of the declaration.)

The declaration draws attention to the barriers to men's participation at the individual, community, institutional, and policy levels: barriers that face not only reproductive health professionals but anyone concerned about public health. Areas for action cited in the declaration include:

- Strategic communication programs addressing the diverse needs of different male audiences, including young men, in order to encourage couple communication and shared decision-making.
- Communication programs must be linked to service delivery.
- Special training may be needed for providers who educate and counsel male clients.
- All health professionals and institutions must advocate policies that encourage and sustain men's participation.

The declaration advocates that "both men and women are reached with information and enabled to access services which meet their varied needs." Difficulties and years of hard work remain, but the main lesson of the Harare Conference is that much can be and is being done to achieve men's participation, often quickly and at relatively low cost.

By building on existing IEC, using existing knowledge about gender differences and communication, and linking that communication to quality service delivery, African health professionals will continue to reach increasingly larger numbers of men of all ages, as well as their partners.

African institutions can only benefit by continuing to share their research and project results and by coordinating project plans as they did in Harare. Two important conferences being planned in Africa in 1997 (the "Men as Partners" Conference in Mombassa in May 1997, and the JHU/PCS conference in West Africa in late 1997) promise to carry on, broaden, and strengthen the spirit and the action of participant pledges and the Harare Declaration.

Conference participants at the African Regional Conference on Men's Participation in Reproductive Health, Harare, Zimbabwe, December 1-6, 1996.

## CONCLUSION

*A journey of a thousand miles must begin with a single step.* —Lao-tzu

This conference was neither the first nor the last step on the road to greater participation of African men in reproductive health, much work has preceded. But, this was an important step —perhaps even a small leap! In bringing together some of the most experienced and capable people in the field, the conference helped to build on research and field experience to clarify issues, focus on priority needs, and map the way for communication efforts in men's participation in reproductive health. The conference focused on increasing communication between men and their partners. The hope is that it also fostered greater communication and collaboration among organizations, institutions, and governments, at the local, national, and international levels, to accelerate the integration of men's issues into the current mix of reproductive health programs.

Results of a brief evaluation survey of participants at the conference support our optimism; most participants found it engaging, informative and relevant. The majority of the participants found the working groups, the case studies, and the field visits the most useful components of the conference; three-quarters of the participants reported that everything was useful, though many would have preferred more time for the advocacy sessions and the working groups.

The pledges were an overwhelming success. Most of the participants felt that the pledge allowed them the opportunity to focus on how to apply what they had learned during the conference to what they are doing in their countries. Typical participant responses included:

> *"Constituted ourselves as a working group on men's issues to represent each of our organizations in Kenya."*
>
> *"Reinforced the strategic direction of existing projects and emphasized the need for integration of men's issues."*
>
> *"Brought about clear thinking—What am I taking back home that will be immediately applicable?"*
>
> *"It brought out possibilities of what [each] participant can do for his/her own country."*
>
> *"One is able to go back with specific recommendations for the way forward with a wealth of knowledge and case experiences to substantiate one's recommendations."*

The journey continues, and important steps will be taken in the near future: at the AVSC-sponsored conference on Men As Partners (their own MAP); in Mombasa, Kenya, in May, 1997; and, in late 1997, with a Francophone conference in West Africa sponsored by JHU/PCS, AED, and others. Sometime, in the not too distant future, the steps will be taken in tandem, each man with his partner, each better informed, purposeful, and happy with...their decision.

# References


Central Statistics Office [Zimbabwe] and Macro International Inc. 1995. *Zimbabwe Demographic and Health Survey, 1994.* Calverton, Maryland: Central Statistical Office and Macro International Inc.

Ezeh, A. C., Michka, S. and Raggers, H. 1996. *Men's Fertility, Contraceptive Use, and Reproductive Preferences.* DHS Comparative Studies No. 18. Calverton, Maryland: Macro International Inc.

Isuigo-Abanihe, U. C. 1994. "Reproductive Motivation and Family Size Preferences Among Nigerian Men," *Studies in Family Planning*, 25:3.

Johns Hopkins Center for Communication Programs. 1997. *Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects, 1986-1996*. Working Paper No. 3, Johns Hopkins Center for Communication Programs/Population Communication Services/Population Information Program, Baltimore: MD.

Kim, Y. M. and D. Awasum. "What are the Particular Aspects of Counseling Male Family Planning Clients? A Case from Kenya." A paper presented at the American Public Health Association Men and Reproductive Health Task Force Workshop, November 1996.

Roudi, F. and L. Ashford 1996. *Men and Family Planning in Africa*. Washington, D.C.: Population Reference Bureau.

# APPENDIX A

## Abbreviations

| | |
|---|---|
| AED | Academy for Educational Development (Washington, DC) |
| AIDS | Acquired Immune Deficiency Syndrome |
| AVSC | Association for Voluntary and Safe Contraception (based in New York, New York) |
| CA | Cooperative Agreement; also Cooperating Agency |
| CAMNAFAW | Cameroon National Family Welfare Association |
| CBD | Community-Based Distribution (or Distributor) |
| CEDPA | Centre for Development and Population Activities (Washington, DC) |
| DHS | Demographic and Health Survey |
| DISH | Delivery of Improved Services for Health (Uganda) |
| DOH | Department of Health |
| FP | Family Planning |
| FPAU | Family Planning Association of Uganda |
| FPHP | Family Planning and Health Project (Ghana) |
| FP/IEC | Family Planning/Information, Education, and Communication |
| FP/MCH | Family Planning/Maternal and Child Health |
| HEU | Health Education Unit |
| HIV | Human Immunodeficiency Virus |
| HRIT | Health Reforms Implementation Team (Zambia) |
| IEC | Information, Education, and Communication |
| IPC/C | Interpersonal Communication and Counseling |
| IPPF | International Planned Parenthood Federation (Lond on U.K.) |
| IPPF/AR | International Planned Parenthood Federation (Africa Region) |
| IUD | Intrauterine Device |
| JHU/CCP | Johns Hopkins University/Center for Communication Programs |
| JHU/PCS | Johns Hopkins University/Population Communication Services |
| KAP | Knowledge, Attitudes, and Practices |
| MCH | Maternal and Child Health |
| MCH/FP | Maternal and Child Health/Family Planning |
| M/MC | Media/Materials Clearinghouse |
| MOE | Ministry of Education |
| MOH | Ministry of Health |
| MOH/FP | Ministry of Health/Family Planning |
| MOI | Ministry of Information |
| NGO | Non-Governmental Organization |
| PCS | Population Communication Services (also see JHU/PCS) |
| PHN | Population, Health, and Nutrition |
| PPAG | Planned Parenthood Association of Ghana |
| PPFN | Planned Parenthood Federation of Nigeria |
| PSI | Population Services International |
| RA | Resident Advisor |
| REDSO/ESA | Regional Economic Development Services Office/Eastern and Southern Africa |
| REDSO/WCA | Regional Economic Development Services Office/West and Central Africa |
| SARA | Support for Analysis and Research in Africa |
| STD | Sexually Transmitted Disease |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Education Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| ZFPSP | Zambia Family Planning Services Project |
| ZNFPC | Zimbabwe National Family Planning Council |

# APPENDIX B

## CONFERENCE AGENDA

**African Regional Conference on Men's Participation in Reproductive Health**
**Harare, Zimbabwe**
December 1 - 6, 1996

| | |
|---|---|
| ***SUNDAY*** | ***1 December*** |
| 2:00 - 4:00 PM | Meeting of Conference Facilitators |
| 4:00 - 6:00 PM | Registration |
| 6:00 - 8:00 PM | Reception |
| ***MONDAY*** | ***2 December*** |
| 7:30 - 8:30 | REGISTRATION (continued) |
| 8:30 - 9:00 | WELCOME REMARKS<br>ZNFPC Representative<br>Patrick Coleman/JHU/PCS<br>Rebecca Kohler/IPPF<br>Lala Toure /SARA<br>Peter Benedict, USAID Director/ Zimbabwe<br><br>KEYNOTE ADDRESS:<br>Minister of Information, The Honorable. Mrs. Mujuru |
| 9:00 - 10:30 | OVERVIEW<br>Lessons Learned: Highlight 8-10 Key Lessons<br>Youth<br>HIV/AIDS<br>Presentation of "Challenges"<br>Conference Objectives/Expectations |
| 10:30 - 11:00 | TEA/COFFEE BREAK |
| 11:00 -1:00 | COMMUNICATION<br>Video Presentation<br>*Overview*: Men's Participation & Communication<br>Case Study 1: Zimbabwe Male Motivation Campaign<br>Case Study 2: Kenya Vasectomy Promotion Project<br>Case Study 3: Ghana Okyeame Approach |
| 1:00 - 2:00 | LUNCH<br>BREAK-OUT SESSIONS |
| 2:00 - 2:30 | Procedure Explained / Topics Detailed (Plenary Room) |
| 2:30 - 3:45 | Group Discussions (Break-out Rooms) |
| 3:45 - 4:00 | TEA/COFFEE BREAK |
| 4:00 - 5:30 | BREAK - OUT SESSIONS continue |

***TUESDAY 3 December***

| | |
|---|---|
| 8:30 - 10:30 | PRESENTATION and OPEN DISCUSSION<br>Key Findings from Break-Out Groups |
| 10:30 - 11:00 | TEA/COFFEE BREAK |
| 11:00 - 11:15 | Break-Out Topics Identified (Plenary Room) |
| 11:15 - 1:00 | COMMUNICATION WITHIN THE CONTEXT OF SERVICE DELIVERY (IPPF) |
| | *Overview:* Counseling for Men; Clinic/worksite/CBD services;<br>Social Marketing and the Private Sector |
| | *Case Study 1:* Nigeria: Integrating modern contraceptive practice into traditional medicine<br>*Case Study 2*: Ghana: Daddies Clubs; Condom promotion; Formation of literacy groups to discuss Reproductive Health; Vocational Center health activities<br>*Case Study 3:* Kenya: Mystery Client Study (AVSC) |
| 1:00 - 2:00 | LUNCH |
| 2:00 - 2:15 | Break-Out Topics Identified (Plenary Room) |
| 2:15 - 3:45 | BREAK - OUT SESSIONS |
| 3:45 - 4:00 | TEA/COFFEE BREAK |
| 4:00 - 5:30 | BREAK - OUT SESSIONS continue |

***WEDNESDAY 4 December***

| | |
|---|---|
| 8:30 - 10:30 | PRESENTATION and OPEN DISCUSSION<br>Key Findings from Break-Out Groups |
| 10:30- 11:30 | TRAVEL to ZNFPC identified Site |
| 11:30 - 1:30 | SITE VISIT |
| 1:30 - 2:30 | TRAVEL back to Hotel |
| 2:30 - 3:30 | LUNCH |
| 3:30 - 4:30 | DISCUSS HIGHLIGHTS/LESSONS LEARNED from the Field Trip |
| 7:30 | DINNER! DANCING! With Oliver Mutukudzi, ZACT Theatre |

***THURSDAY 5 December***

| | |
|---|---|
| 8:30 - 9:30 | POLICY/ADVOCACY (AED/SARA) |
| | *Overview*: What is advocacy?; Essential elements of advocacy; Current policy environment; Q & A |
| 9:30 - 11:00 | Brainstorming session on advocacy objectives/recommendations from the local to the national level/from the micro to the macro level. |
| 11:00 - 11:30 | TEA/COFFEE BREAK |
| 11:30 - 1:00 | BREAK-OUT SESSIONS: Choosing an advocacy objective |
| 1:00 - 2:00 | LUNCH |
| 2:00 - 3:30 | BREAK-OUT SESSIONS: Understanding the Decision Making Process |
| 3:30 - 4:00 | PRESENTATION and OPEN DISCUSSION<br>Key Findings from Break-Out Groups |

***FRIDAY 6 December***

| | |
|---|---|
| 8:30 - 9:30 | Plenary Session Presentation: Recommendations for Men's Participation visa vi Opening Challenges |
| 9:30 - 10:30 | "Pledges" |
| 10:30 -11:00 | TEA/COFFEE BREAK |
| 11:00 - 12:00 | "Pledges" continue |
| 12:00 - 12:30 | Donors' Reaction |
| 12:30 - 1:00 | LAUNCH of the *Men's Sports Initiative and Challenge CUP* |
| 1:00 - 1:30 | CEREMONIAL CLOSURE |
| 1:30 - 2:30 | LUNCH |

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**APPENDIX D**

*African Regional Conference on Men's Participation in Reproductive Health*

**Conference Participant Pledges**

| COUNTRY/ PARTICIPANT | OBJECTIVE(S) | INTENDED POPULATION | ACTIVITIES | TIME/COST | INDICATORS | LESSONS FROM CONFERENCE |
|---|---|---|---|---|---|---|
| **CAMEROON**<br>Family Welfare Association.<br><br>Contact: Marc Azombo) | To integrate men's participation in RH activities into ongoing FP/ Nutrition/ parasite control project. | Men and young men in 2 districts | 1. Develop training curricula;<br>2. Train 40 male motivators.<br>3.Produce male-focused IEC materials | 2 yrs<br>(1997-98)<br><br>$15,000<br>for TA from JHU/PCS. | 1. No. of men and young men talking with their partners about FP, RH, and safer sex;<br>2. No. of men and young men practicing safer sex;<br>3. No. of men and young men supporting their partners' use of FP methods;<br>4. Increased CPR in each district. | Integration of men's RH issues it FP;<br><br>Advocacy at district level. |
| **CAMEROON**<br>Presbyterian Church<br><br>Contact: Pastor Peter Ndumi WaDanji | To integrate men's RH training into 200 existing Christian men, women and youth church groups.<br>2. Integrate men's RH training into church training institutions. | National, 200 leading trainers; over 15,000 men women and youth. | 1.Train 200 leaders of men's religious groups to use IEC materials to training district leaders in IPC<br>2. Develop community drama and choral music to support RH knowledge<br>3. Include RH training module into the Church health manual | 2 yrs.<br>(1997-98)<br><br>$30,000;<br>Church can Match Funds | 1. Over 200 leaders trained in IPC - FP/HIV/AIDS and STDs.<br>2. RH counseling module included in church health manual ;<br>3. RH training integrated into church vocational schools. | Entereducate RH activities in church rallies; Community mobilization. |
| **ETHIOPIA**<br>National Office of Population, Woman and Youth Dep't<br><br>Contact: Genet Mengistu | 1. To create awareness about men's roles in RH issues, both as providers and users, in all RH institutions and programs;<br>2. Integrate men's participation strategies in IEC component of the national population plan of action. | National; Managers and Directors of RH institutions and programs. | 1. National consensus—building seminar for Managers and Directors of RH institutions and programs.<br><br>2. Draw up a plan of action | 1997-98<br><br>$20,000 | 1. No. of institutions/programs in Ethiopia promoting men's participation in RH.<br>2. Participation of men as clients or providers of RH services. | 1. Advocacy workshops; 2. Communication strategies for men (Radio, TV and traditional media). |
| **GAMBIA**<br>Agency for Development of Women & Children;<br><br>Contact: Ebrima Jarjou | 1.Increase men's participant-ion in RH among IMAMS<br>2. Train community opinion leaders (IMAMS) in IPC. | 1.Community opinion leaders.<br>2. Men aged 18 and older in program areas. | 1. Advocacy with community opinion leaders.<br>2. Training in IPC.<br>3. Community mobilization for service utilization. | 2-3 yrs<br><br>$50,000 US | 1. Increase by 10% the number of men counseled about RH each year.<br>2. Increase # trained IPC.<br>3. Increase in # leaders participating in RH.<br>4. Increase CPR each year by 10% (25% during life of project). | 1. RH advocacy training.<br>2. IPC for quality of care. |
| **GHANA**<br>Planned Parenthood Association<br><br>Contact: Nii Adote Addo | Increase knowledge of RH and gender issues among young men. | Young men aged 15 to 25 in Upper West region | Community IEC activities. | 1998-2000<br>(3 yrs)<br><br>$300,000 | 1. 90% of intended audience will be knowledgeable of RH and gender issues.<br>2. 75% will practice safer sex. | Advocacy - Grass Root programs to ensure sustainability |
| **GHANA**<br>Ministry of Health;<br><br>Contact: Mary Arday-Kotei | 1. Increase knowledge of contraceptive methods among men and their partners;<br>2. Promote contraceptive use among men and women of reproduction age. | Men and women of reproductive age in one region. | 1. Reprinting of IEC materials<br>2. Challenge cup initiative<br>3. Organize draught game competitions<br>4. Retrain service providers | Two yrs.<br><br>To be mobilized | 1. Exposure to challenge cup campaign; 2. Discussion of RH among organized groups;<br>3. Knowledge of contraceptives;<br>4. Attitudes towards FP and service providers;<br>5. Use of contraceptives. | -Advocacy tools at all levels;<br>- sustainability factors; -<br>Integration of men in RH. |

**APPENDIX D**

## African Regional Conference on Men's Participation in Reproductive Health
## Conference Participant Pledges

| COUNTRY/ PARTICIPANT | OBJECTIVE(S) | INTENDED POPULATION | ACTIVITIES | TIME/COST | INDICATORS | LESSONS FROM CONFERENCE |
|---|---|---|---|---|---|---|
| **GHANA**<br>National Population Council Secretariat;<br><br>Contact: Dr. Kwame Amapomah, Dir., RH Division | To obtain greater commitment from all non-governmental as well as governmental agencies involved in RH to integrate male issues at all levels of their programs. | National RH program implementors | Interaction with high level policy makers and all practitioners in Ghana, including heads of CAs | 3-5 years<br><br>Part of existing budget | 1. Increased CPR in Ghana;<br>2. Reduction in TFR from 55.5 now to %.0 in 2000;<br>3. Increased couple communication on RH issues. | '.. the new vision of the National Population Council .. the need to involve men in all RH programs. ...this is a new commitment following what we've seen from this conference.' |
| **IPPF** - Africa Region;<br><br>Contact: Laurencia A. & Rebecca Kohler) | To sensitize regional programme and management staff and policy makers about men's participation in RH. | CEOs of RH organizations, IPPF program staff, Mgt staff, policy makers, other NGOs in RH; the Federation of Kenya Commerce; mass-media reps - KBC & donor agencies. | 1. Meet and urge RH groups & FPAs to design and implement male-friendly programmes.<br>2.Debrief USAID/Kenya and other donors about Harare conference<br>3.Newspaper articles, radio and TV broadcasts and other media events to sensitize men about RH issues;<br>4 'Men in Focus' month programs including 'Men and HIV/AIDS', 'Men and the Family', 'Young Men', etc. | Jan. 1997 to June 1998<br><br>Staff Time (under IPPF core funds) | 1. Sensitized program and mgt staff of governments and NGOs;<br>2. policy makers who are informed on men's sexual and reproductive health;<br>3. Increased ability of IPPF program staff to disseminate information to their FPAs and implement men's RH activities;<br>4. Number of seminars held on men's RH.<br>5. Number of news items on men's participation; | Information materials;<br>- linkages with colleagues who can provide support/more information;<br>- advocacy knowledge and skills. |
| **KENYA**<br>Family Planning Assoc. of Kenya<br><br>Contact: Peter Mwarogo | Increase RH services delivery to men. | Male motivators in Kenya; Football fans and general public | Training male motivators to counsel men on RH/FP/ STD/HIV prevention, using a checklist.<br><br>- Organize RH Challenge CUP Initiative | Three phases on-going.<br><br>Kenya Male Motivation Programme- matching funds- $50,000. | 1. No. of Motivators trained to counsel men;<br>2. No. of men reached in outreach by Male Motivators.<br>3. Increased use of RH services due to Male Motivators.<br>4. Men exposed to Challenge Cup campaign | Integration of IPC in RH. |
| **KENYA**<br>INTRAH<br><br>Contact: Jedida Wachira | Improve provider training to increase men's participation. | Service providers; trainers, Program Officers and Supervisors | 1. Improve existing RH training systems. 2.Review client guidelines on RH services and include a minimum service package for men and young men. | By January 13, 1997 One day workshop ($1,000) | 1. Increased number of men receiving quality RH services in FPAK clinics.<br>2. Service package for men and young men. | -Elimination of cultural barriers;<br>-Integration of RH;<br>-Audience segmentation. |
| **MALAWI**<br>Banja la Mtsogolo Project-"Man-to Man"<br><br>Contact: Emmanuel Sabakati | Increase men's participation in RH as motivators and CBD workers. | Men of reproductive age in Man-to-Man Program | 1. Include more men's activities in the CBD programme;<br>2. Include the counseling of men on RH in the training of CBDs;<br>3. Recruit & train more male CBDs.<br>4. Form men's RH clubs in industries; | 2-3 years<br><br>Part of on-going programmes. | 1. Increase condom users; increase vasectomy users; increase men attending clinics.<br>2. Trained motivators.<br>3. Viable programme activities | -IPC integration in CBC curriculum.<br>-Men's Club. |
| **MAURITIUS**<br>Family Planning Association<br><br>Contact: Sangeet Jooseery | Evaluate the quality of RH services in one FPA and Four public clinics. | Service providers and clients | 1. Conduct a mystery client study;.<br>2. Develop a quality improvement plan in a model FPA clinic;<br>3. Demonstrate effectiveness of quality of services in increasing men's participation. | Two yrs.<br><br>$10,000 US | 1. Changes in clinic service delivery systems to include more men.<br>2. Attitudes of service providers toward male clients<br>3. No. of new clients recruited; | -Kenya Mystery Client Study<br><br>-Quality of Care (IPC) |

**APPENDIX D**

## African Regional Conference on Men's Participation in Reproductive Health
## Conference Participant Pledges

| COUNTRY/ PARTICIPANT | OBJECTIVE(S) | INTENDED POPULATION | ACTIVITIES | TIME/COST | INDICATORS | LESSONS FROM CONFERENCE |
|---|---|---|---|---|---|---|
| **MAURITIUS**<br>FPA<br><br>Contact: Sangeet Jooseery | Improve policies to provide sexual and RH services to adolescents, unmarried men/women. | Decision-makers and opinion leaders | 1. Build alliances with RH partners, forming an advocacy team;<br>2. Train and orient members of the FPA staff in advocacy. | 1 year<br><br>$15,000 US | 1. Existence of an advocacy team.<br>2. # of trained staff in advocacy.<br>3. Teens/unmarried receiving RH services | -Advocacy<br>-Reduction of challenges. |
| **SENEGAL**<br>Population Council Africa: OR/TA Proj. II West & Central Africa<br><br>Contact: Diouratie Sanogo | To measure the impact of improved quality of service on (a) continued use of RH services, and (b) the client's ability to achieve reproductive intentions. | New FP clients selected among women and men in a model clinic in Senegal | Existing operations research study to improve the quality of FP services in a model health center.<br><br>Upgrade logistics & improve training of health personnel and others. | Jan 1997 to June 1998 (18 months)<br><br>$90,000 to be funded by USAID Washington (PC/AF OR Project). | 1. Increased number of FP clients/ couples<br>2. Increased mean level of achievement of reproductive intention for each cohort followed in this study. | Advocacy, policy formulation, and alternative strategies to encourage partner communication. |
| **SIERRA LEONE**<br>Planned Parenthood Association<br><br>Contact: Jacomo Bangura | Advocate for men's participation in RH. | Community opinion leaders & organized group of young adults and men aged 15 to 55 | 1. Advocacy through mass media, workshops;<br>2. Grass roots mobilization<br>3. Publicize men's project in PPA's magazine. | Two yrs.<br><br>$15,000 | 1. # Participants at advocacy workshops.<br>2. Mass media activities. | -Advocacy |
| **SOUTH AFRICA**<br>Dept. of Health<br><br>Contact: Eleen Retief | 1.To include men's participation activities in RH in strategic and operational plans at all levels in public & private sectors;<br>2. To promote male-friendly clinics to achieve gender equity in service delivery. | Senior level personnel of the DOH, Directors, NGO Managers. | 1. Include men's participation in RH as a national objective in DOH/MCH and Women's Health document<br>2. Include men's participation issues in training and research programmes<br>3. Encourage the DOH Task Team for Youth to promote men's participation in RH<br>4. Brief opinion leaders about the Harare conference. | Two yrs.<br><br>Included in annual DOH budget | 1. Men's participation in RH goal defined in S. Africa;<br>2. Training module on men's RH in training programmes.<br>3. Surveys include men's participation activities;<br>4. Networking among men and young men's groups;<br>5. Widely distributed Harare conference report. | -Advocacy<br>-Integration of IEC/RH<br>-Gender Equity |
| **SOUTH AFRICA**<br>Planned Parenthood Assoc.<br><br>Contact: Buti Baloyi & Kate Stratten | Create Task Team to plan the implementation of an efficient and effective men's participation in RH programs in South Africa. | South African men 18-55 yrs. old, opinion leaders, NGOs. | 1. Create task force;<br>2. Literature review on S. African men & RH; 3. Build networks with RH organization;<br>4. Develop strategic plan of action;<br>5. Fund raising/donor support. | 6 month - 1 year<br><br>40,000 Rand | 1. Establishment of a Task Team;<br>2. Plan of action;<br>3. Comprehensive budget;<br>4. Continued funding. | Case studies, site visits small group discussion; advocacy & lobbying. IPPF support: funding & technical assistance with IEC and implementation. |
| **TANZANIA**<br>Federation of Trade Unions<br><br>Contact: T. Assenga | 1. Increase KAP in RH among male workers;<br>2. To increase the commitment of the employers in existing Male Motivation Project FP services.<br>3. Integrate FP services into standard benefit for employees in collective bargaining agreements. | Employees and employers; over 40,000 workers and employees. | 1. IEC/RH services for employees<br>2. Encourage employers to provide materials, premises and financing educational activities at the worksite<br>3. Introduce cost-sharing between employers & employees for RH services.<br>4. Increase voluntarism among RH service. | Ongoing project: 1994/5 to 1996/97 3 yrs.<br><br>Available funds: $470,000 from UNFPA | 1. Number of male employees using condoms;<br>2. Number of employees supporting their wives' practice of FP;<br>3. Number of volunteers in RH.<br>4. Modification in CBA;<br>5. Employer support for RH at booksite. | -Sustainability strategies;<br>-Advocacy;<br>-Quality of care-counseling. |

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| **TANZANIA**<br>MOH, Health Education Unit<br><br>Contact: Elizabeth Mapella | Integrate men's participation into existing National RH and child survival program | Adult men, husbands partners of men 18-45; Community Health providers, community leaders | 1. Revise community health worker training curricula to include men<br>2. Design, develop, and pretest messages for men using appropriate IEC channels<br>(e.g. sports & drama);<br>3. Organize Challenge CUP Initiative. | 1-2yrs.<br><br>Part of National Reproductive Health Programme | 1. Health Workers curriculum includes men's participation module;<br>2. Mass medica messages for men's RH;<br>3. Challenge CUP activities. | Advocacy; men's programs in different countries. |
| **TANZANIA**<br>USAID<br><br>Contact: Michael Mushi | 1.Increase men's participation in RH in USAID mission programming<br>2. Reinforce partner communication in RH programs of USAID | Self, USAID colleagues, USAID-supported program managers | 1. Improve personal communication with spouse about RH.<br>2. Integrate men's participation activities into appropriate USAID mission programs/ | 1997<br><br>Part of AIDS/ Tanzania Progam | 1. USAID programming includes men's participation in RH. | -Advocacy training;<br>-Integration of men's participation in IEC/RH<br><br>**Observation:** |
| **UGANDA**<br>MOH, MCH/FP Dept.<br><br>Contact: Elliot Munaaba | Introduce young men's reproductive issues in existing adolescent health program. | Young men 13-24 in ten districts | 1. Advocate for young men's participation in RH.<br>2. Create an institutional framework for young men's RH activities.<br>3. Develop training curriculum in RH.<br>4. Retrain RH staff.. | Ongoing<br>T.D. thru (UNFPA, UNDP, Swedish SIDA) | 1. FP awareness among young men.<br>2. Age-specific awareness of STD/ HIV prevention.<br>3. Age-specific CPR, (condom use).<br>4. Lower age-specific fertility among youth. | IEC strategies; field trip experience. |
| **UGANDA**<br>Family Planning Assoc.<br><br>Contact: Elly Mugumya | Increase men's participation in RH | Men up to age 34 | 1. Train male CBD agents.<br>2. Sensitize communities.<br>3. Develop IEC materials for men.<br>4. Provide RH services to men in existing sites.<br>5. Challenge CUP initiative under on-going sports activities | 1997-98<br><br>Available<br>$160,000 | 1. CBD sites established.<br>2. Male CBD agents recruited.<br>3. IEC meetings held in communities.<br>4. IEC materials produced.<br>5. Number of men using RH services. | Strategies for advocacy and sustainability;<br>use of folk media |
| **ZAMBIA**<br>Information Services<br><br>Contact: Patrick Jabani | Integrate men's participation into all RH information programs, including all STD/HIV and FP, IEC activities. | Zambia Information Services, IEC Subcommittee, Population Education Project, etc. | 1. Advocate with donors to support men's participation in RH.<br>2. Research on male KAP and IEC effectiveness reaching men.<br>3. Develop IEC materials to increase men's participation.<br>4. Training IEC staff to improve IEC for men. | Ongoing.<br>Any costs<br>To be determined and mobilized. | 1. More men visiting clinics and using services.<br>2. More men being reached with IEC.<br>3. More men communicating with their spouses. | -Data from other countries, advocacy guidelines.<br>-Advocacy. |
| **ZAMBIA**<br>MOH/MCH Unit<br><br>Contact: Grace L.Sinyangwe | To promote male participation in RH through IEC activities. | Men in 13 districts in UNFPA-funded provinces | 1. Research current perceptions on role of men in RH;<br>2. Study tour for IEC personnel from 13 districts;<br>3. Produce IEC materials;<br>4. Sensitize leaders in 13 districts | Jan. 1997-June 1998<br><br>Cost to be determined. | 1. Participation in study tour.<br>2. Research implementation report.<br>3. IEC materials package available.<br>4. Leaders supporting RH for men.<br>5. Increased utilization of RH services | Literature shared; information from all presentations; field visits. |
| **ZAMBIA**<br>JHU/PCS Family Planning Services Project<br><br>Contact: Alex Katambala | 1. Increase male participation in FP programme. | All men of reproductive age | 1. Produce male IEC materials.<br>2. Promote partner communication<br>3. Train providers to counsel men.<br>4. Establish CBD and EBD services.<br>5. Build social support groups and clubs in RH | 3-5 yrs. starting Dec. 96<br><br>Needs $20,000 | 1. Number of "Circles of Friends" support groups established.<br>2. Number of trained service providers. | Working with community groups. |

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| **ZIMBABWE**<br>National Family Planning Council<br><br>Contact: Wisten Ngulube | 1. To increase couple communication.<br>2. To increase young men's responsibility towards RH. | Men age 18-50<br>(Young men 18-24) | 1. Reinforce young men's campaign thru male motivation program.<br>2. Pilot Challenge Cup in RH. | 6 mos. to 3 yrs.<br><br>Needs $10,000 | 1. Number of men who report having discussed FP method with spouse.<br>2. Shift from short- to long-term FP methods.<br>3. Number of men using five centers.<br>4. Number of men expressing positive attitudes towards family planning. | Young men as a segment; communication within service delivery; using positive traditional opinion leaders; sustainability; advocacy<br>manual. |